R.N.

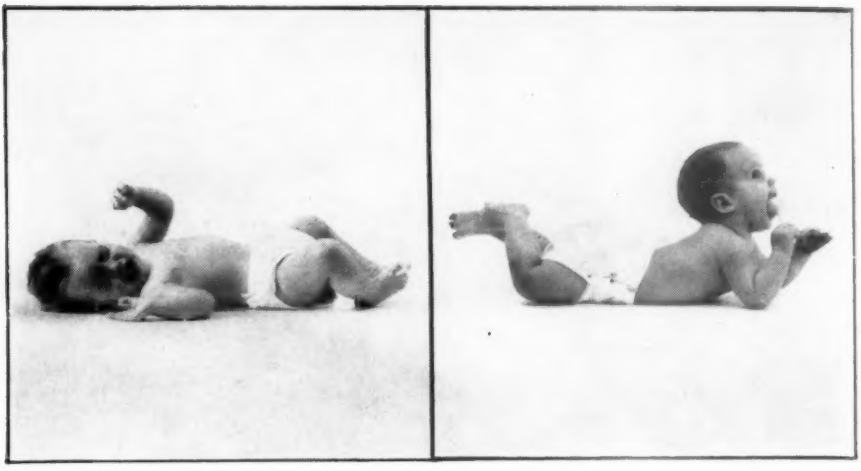
a journal for nurses

- Pharmacophobia
- Nursing's Middleman — the Supervisor
- Retrolental Fibroplasia

ST. FRANCIS SCHOOL OF NURSING WICHITA KANS

April 1954

ITCHING . . .



This child cries, can't sleep and is driving his parents to distraction.

This child enjoys life— his itching has stopped.

Calmitol makes the difference

"Preferred"[1] by physicians for safe relief of pruritus. Soothing and bland, Calmitol is appreciated by both baby and mother. Its safety and freedom from sensitizing action make it the antipruritic of choice in pediatric practice. Calmitol is free from the danger of the "therapeutic rebound" of harsh phenol preparations and topical antihistamines.

the bland antipruritic

1½ oz. tubes and 1 lb. jars

1. Lubowe, I. I.: New York State J. Med. 50:1743, 1950.

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R.N.

Contents

April 1954

Vol. 17, No. 4

CCA NBP

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eeny

meeny

miny

mo!

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SYRINGES

Presently available in 2 co size only.
Packaged individually or in units of
ONE DOZEN.

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with **cod liver oil**

are safe, conservative therapy in **hemorrhoids**

more effective.... because they provide healing crude Norwegian cod liver oil (rich in vitamins A and D and unsaturated fatty acids, in proper ratio for maximum efficacy).

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safe, conservative..... contain no styptics, narcotics or local anesthetics, so they will not mask serious rectal disease. Easy to insert and retain.

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How do Dennison Diaper Liners aid baby health?

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Urine, unincubated, control	0.12
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Same urine, incubated with Dennison Diaper Liner for 27 hrs. at 37°C.	.19

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Dennison Diaper Liners save mothers from scrubbing and soaking badly stained diapers. When it's time for a "change," mother can merely lift out the liner and dispose of it. Dennison Diaper Liners are lint-free, silky soft. They help cloth diapers last longer — make baby care easier in *many ways.*

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PHOTOGRAPH BY RUZZI GREEN

When the reflection reflects on her... suggest

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METHYLCELLULOSE WAFERS*

You can help your overweight friends look better and feel better by telling them about 'MELOZETS'—the methylcellulose wafers that look and taste like graham crackers.

A "drugless" help to any reducing regimen, each 'MELOZETS' wafer gives a sense of satisfying fullness—yet supplies only about 30 calories.

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In conversion syndrome therapy,
when fast pain relief is needed in
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—the analgesic effect continues over prolonged periods of time.

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TABLETS

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Debits and Credits

Poor Standards

Dear Editor:

I'm beginning to think some R.N.'s in supervisory positions are taking advantage of practical nurses and making them the "work horses" of some hospital staffs. I work in a TB sanatorium. Since the advent of the practical nurse schools and the availability of practical nurses, there has been no attempt to employ any registered nurses in this institution except as supervisors for each shift. The practical nurses know they are not getting the right kind of supervision, and resent this fact. The supervisors not only make no attempt to help out on either routine care or in emergencies, but they spend most of their time in their quarters drinking coffee and watching television.

Frequently, there is no nurse to put on a shift on some ward. Instead of the supervisor taking the ward for the time being, she calls in an aide, puts the evening sedatives and narcotics on a tray and gets them charted by 7 P.M., and back she goes to TV. The aide is then left to give the medicines, yet everything is according to Hoyle since there is a supervisor, even if she is in her quarters, and she has dispensed the narcotics, even though she did not see that the patients took them. Our practical nurses have questioned this procedure of charting medicines before they are given. I feel that such a routine is setting a very poor example and is lowering the standard of patient care.

Also, we have "nurses" here who have anywhere from six months to two years of nursing school but who stopped their education for various reasons. Since they wear the full uniform of a professional nurse, they are passing as R.N.'s. And, being neither fish nor fowl, these "nurses" do not pay dues to any organization, either professional or practical.

Is this happening in other parts of the country? I don't blame the practical nurses for such a situation, but the nurses in high places who allow such things to happen are deserving of our censure.

R.N., Indiana

Help!

[In *Debits and Credits* last May, we published a letter from Mrs. Elizabeth McKenzie of Maywood, New Jersey, asking nurses to send her their old nylon stockings. For every 18,000 pairs of stockings turned in to a nylon converter, her ladies' auxiliary earned enough money to purchase a new television

set for Greystone Park, a state hospital in New Jersey.

In December, 1953 we published her second letter, in which she reported that her auxiliary had fulfilled its quota and had no further use for stockings. Apparently, **R.N.** readers who read the first letter missed the second, for Mrs. McKenzie is being inundated by bundles of stockings—now over 6,700 additional ones are stored in her garage and cellar, plus innumerable unopened packages. She's more than grateful, but . . . Readers who are interested in donating their nylons to this worthy cause are therefore requested to send them directly to Greystone. The address: Rags for Greystone Park, Greystone, New Jersey.]

THE EDITORS

New Motto

Dear Editor:

Letters, editorials, and articles in your dynamic and thought-provoking magazine for the past few months, plus the syndicated articles which you referred to in your January editorial, have moved me to write my thoughts. It is a known fact to all people in all walks of life that there is good and evil. We find it all about us—and so it is with our profession. For many years I have had a deep conviction that we have lost sight of self-evaluation. Let's not "pass the buck."

When every single professional nurse realizes that her future depends upon those holding office, then she will become part of organized nursing. How nursing is nationally, state, and locally organized, what its organizations have done, future plans, and effects plans have on all of us should be a current subject in schools of nursing. When we stress organizational importance and its endeavors this early, I feel that nursing will establish an irreproachable standard which will excel anything we have read in its history.

I have observed since 1943 that we have been steadily losing our basic criteria in nursing. We have divorced ourselves from each other, set up individual sails, and gone out to sea on an uncharted, unending course. When once again we feel that we need each other and walk with God, the great Physician, then and then only will nursing justify the ideals set forth in the Nightingale pledge.

I'm proud of my profession, and I'm sure other nurses are equally proud. Let us all resolve to evaluate ourselves as nurses, strive to attain sound leadership in our communities, establish good public relations, and above all, rely upon teamwork. "United We Stand" might be a good motto for our proud profession.

MARION E. TERLIZZI, R.N.
HUNTINGTON, W. VA.

Ready Reference

Dear Editor:

I am willing to bet that I may be one of your oldest subscribers, and I would feel lost without **R.N.** I believe it contains more valuable in-

Massengill POWDER

acid vaginal douche

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formation for its size than any nursing magazine on the market. And it is responsible for my fine book on drugs, which I call "Reference Drug Book." This contains all the drugs clipped from *Drug Digest* and pasted in a scrap book. I've referred to it many times during my experience as a private duty nurse.

(Mrs.) Marie W. Garvue, R.N.
Minneapolis, Minn.

[*Sets of* **R.N.***'s third reprint of 48 Drug Digest cards are still available from the Editorial Department at $1 a set.*—The Editors]

Help a Hobbyist?

Dear Editor:

I'm looking for small china dolls which were made before 1917 up until about 1941. Both Japan and Germany made them before both World Wars. I would like to have any parts of such dolls which other readers may still have—I could put them together to make a complete doll. I have a small collection of dolls, and my hobby is getting old dolls and fixing them up.

Elizabeth W. Grietsell, R.N.
Detroit, Mich.

Why the Oversight?

Dear Editor:

Nurses are constantly lamenting the lack of or loss of the spirit of nursing. Perhaps when we are asking the now famous question, "What is happening to our nurses?" we ought to ask also, "Why have nurses permitted their professional organizations to completely discard the spiritual?"

In a statement about nursing education, the Joint Commission for the Improvement of the Care of the Patient has advanced the following definition of nursing, which was subsequently endorsed by the boards of directors of the NLN and ANA and the boards of trustees of the AHA and AMA: "Comprehensive nursing includes physical and emotional care of the patient; care of his immediate environment; carrying out treatments prescribed by the physician; teaching the patient and his family the essentials of nursing care which they may have to perform; participation in activities for the prevention of disease and the promotion of health, and delegating to other workers activities which they can perform for specified patients."

Is there any valid reason for omitting the spiritual? The definition should read: "Comprehensive nursing includes physical, emotional, and *spiritual* care of the patient, etc."

In *Nursing for the Future*, Esther Lucile Brown writes: "Certainly technical competence would never enable the nurse to minister to the spiritual health and the spiritual environment . . . Yet it is these very plus values, under whatever name given them, that leaders of the nursing profession since the days of Florence Nightingale have held truly essential. It is these values that raise nursing from the level of a craft to that of a profession; that distinguish the professional nurse from the person whose almost ex-

Grandpa never stays home
since he started taking

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It's true! Older folks feel better and enjoy themselves more, when they have all the vitamins and minerals they need.

And they treat their families, friends and nurses a lot more pleasantly, too!

The GEVRAL line is increasingly recommended by doctors to prevent vitamin and mineral deficiencies, not only in older people, but in middle-aged folks as well. The line consists of GEVRAL* Geriatric Vitamin-Mineral Supplement Capsules, GEVRAL PROTEIN Geriatric Vitamin-Mineral-Protein Supplement, GEVRABON* Geriatric Vitamin-Mineral Supplement, a fine wine-flavored elixir that stimulates appetite, and GEVRINE* Vitamin-Mineral-Hormone Capsules.

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clusive preoccupation is with the prescribed physical care of a sick person."

Have nurses thrown away their spiritual values to keep up with the modern, atheistic, communistic world? Are we afraid to allow the word spiritual to appear in our national magazines for fear of offending the poor, benighted few who have lost all faith in anything their senses cannot grasp?

Is the loss or neglect of the spiritual in nursing at the basis of many of our problems in nursing?

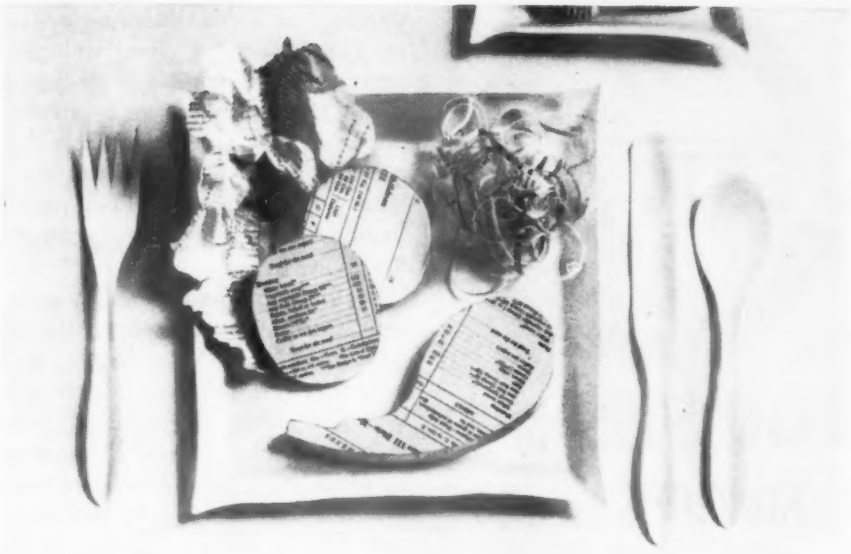
SISTER M. EVARISTA, S.P.S.F.
COVINGTON, KY.

On Keeping Pace

Dear Editor:

Nurses and teachers alike seem to be plagued by moral ethics whenever they seek to organize effectively. Labor leaders contend their only effective weapon is the right to strike. Well—I don't find this near as horrifying as hiding behind a cloak of martyrdom, calling on nurses to seek their glory in service and efficiency. It takes saints to do this, and I think we are a little presumptuous to assume there are enough "evolutionized" women to fill the role.

Let's admit we are human, we can respond to hot and cold, love, hate, and fear, and we, too, must live a well-balanced life of working, playing, sleeping, and dreaming. Let's not stereotype nurses or minimize their needs. Remember, we draw our recruits from young women conditioned to conveniences like tele-



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look good on paper

but patients eat food!

It's easy to prescribe a diet . . . and it will be just as easy for patients to follow one, if Ac'cent is recommended with the diet.

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phones, airplanes, dishwashers, and television sets. A few well-timed strikes, leaving nurses in emergency rooms only, would have averted the deplorable situation in many hospitals today. A few patients would have suffered, but it isn't comparable to those who suffer now because of the shortage.

Methods of nursing and teaching are constantly changing with the growth of man's knowledge. It is necessary for nurses to have extra time and money if they are to begin to keep up with these changes. As hospitalization plans have made care available to more people, the nurse's aide has a definite place, for the nurse herself must step out and help lead in the care of the ill. No longer is the nurse's main job to meet needs only. She should foresee and often forestall those needs. Young girls entering careers look for individuality, originality, and the ability to keep pace with a changing world. Nursing promises these things, but too often it bogs down into a routine with long hours and little pay. Economic factors have a direct effect upon keeping sufficient nurses in service, and economically we should keep pace with the rest of the world.

FERN LEATHERWOOD, R.N.
CHICAGO, ILL.

[*What price evolution?*—THE EDITORS]

PNR

Dear Editor:

The Professional Nurses Reserve, whose immediate aim is to establish retirement homes for nurses, hopes

clinical statistics show

RIASOL is better for PSORIASIS

In a series of 231 cases of psoriasis[1] receiving various methods of treatment, remissions occurred in only 16.5%.

In a special series[2] of stubborn cases, all of which had failed to respond to other treatments, RIASOL was the only medication applied.

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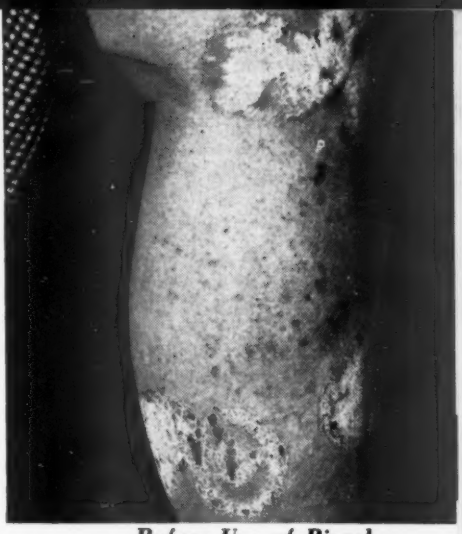
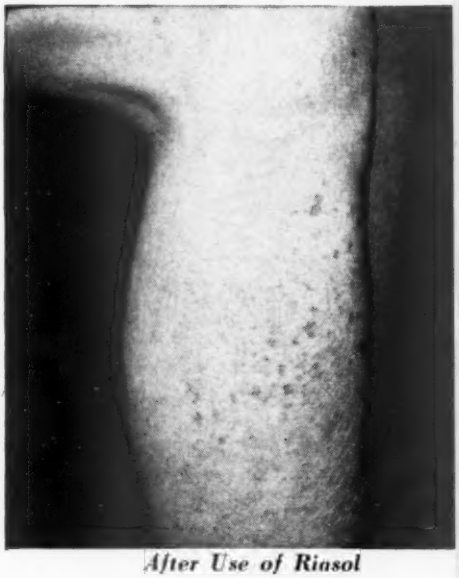
Apply daily after a mild soap bath and thorough drying. A thin invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

RIASOL is supplied in 4 and 8 fld. oz. bottles at pharmacies or direct.

1. *Arch. Dermat. & Syph.* 35:1051. 1937.
2. *Med. Rec.* 151:397. 1940.



Before Use of Riasol



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RIASOL FOR PSORIASIS

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The organization is to be national, and headquarters will be in Texas.

FLORA A. MURRAY, R.N., PRES.
PROFESSIONAL NURSES RESERVE
326 PRINCETON AVE.
SAN ANTONIO 1, TEX.

Suggestion

Dear Editor:

I just want to tell you that I've finally found a good place for my past issues of magazines, and thought maybe it would give some of the other readers of R.N. a similar idea. I send them to a little missionary sister in Krobo, East Africa. Before, I used to put them in the hospital library for the student nurses, but I found many other nurses had the same idea. A couple of times a year I make up a package of magazines, American goodies, and some of the necessities of life and send them to my friend in East Africa. We can't all be missionaries, but it takes so little effort to help those who are.

(MRS.) FLORENCE S. SLUPPICK, R.N.
WAUKEGAN, ILL.

IT'S JUNE IN JANUARY . . . for the hibernating Trichophyton mentagrophytes (arch criminals in athlete's foot) in the humid heat of the shower room or in the damp warmth of wool-stockinged feet. The attack against athlete's foot is a *year-round* attack. The *winning* attack is with OCTOFEN LIQUID and POWDER. *Athlete's foot will never get a foothold.*

OCTOFEN LIQUID — ***Fungicidal:*** Contains power-charged 8-hydroxyquinoline (2.5% in 43% ethyl alcohol solution) *Kills* causative fungi in two minutes flat — *in vitro.* Clinically effective in 90% cases tried.[1] *Treatment:* swab affected parts liberally in the office and at home until cured. Popular with patients, OCTOFEN LIQUID is non-irritating, greaseless, non-staining, quick-drying.

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FOR OPTIMAL RESULTS: Use OCTOFEN LIQUID *and* POWDER in combination as described for maximum therapeusis and prophylaxis.

1 Exp. Med. & Surg., 7:37, 1945.

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For proctoscopy and sigmoidoscopy [1, 2]
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In ready-to-use polyethylene "squeeze bottle" . . . sanitary rectal tube sealed in cellophane envelope . . . distinctive rubber diaphragm prevents leakage and controls rate of flow. Each single use unit of 4½ fl. ozs. contains in each 100 cc., 16 Gm. sodium biphosphate and 6 Gm. sodium phosphate — an enema solution of *Phospho-Soda* (Fleet), as effective as the usual enema of one or two pints . . . provides complete left colon catharsis in two to five minutes.

(1) Sweatman, C. A.: J. So. Carolina M. A., 49:38, 1953. (2) Marks, M. M.: Am. J. Dig. Dis. 18:219, 1951. (3) Hamilton, H., in Trans. 5th Am. Cong. Obst. & Gyn., Mosby, 1952, p. 69. (4) Burnikel, R. H., & Sprecher, H. C.: Am. J. Dig. Dis. 19:191, 1952. (5) Marks, M. M., Personal Communications, 1952-53.

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Prompt . . . Thorough
The FLEET ENEMA
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disposable unit

New **DAVOL** TERMI-CAPS*

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For TRUE Terminal Sterilization
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New, efficient, rubber nipple covers minimize the danger of contamination during the whole preparation and storage period. Davol Termi-Caps are placed lightly over nipples before sterilization . . . pressed down firmly with a quick twist while bottles are cooling.

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R543

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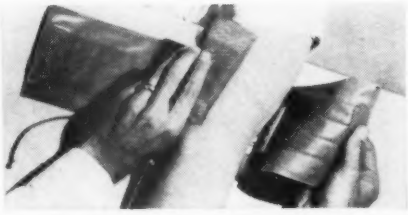
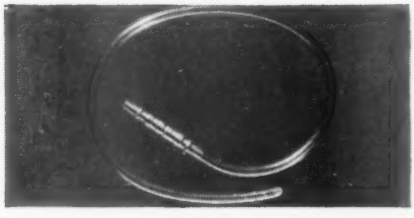
New on the Market

Here's a bloodpressure cuff that can be washed with soap and water. Made of nylon and coated with long-wearing Vinyl plastic, the new Air-Lok Cuff is easily applied, even to large-sized arms. Full, even compression of the artery is assured by its manufacturer, the W. A. Baum Co., Inc., Copiague, N. Y., which is offering literature and a free booklet on the proper function of bloodpressure cuffs.➤



Plastic products are featured by Pharmaseal Laboratories, Glendale 1, Calif., which makes the durable K-25 Oxygen Connecting Tube, and the K-20 Expendable Plastic Oxygen Catheter (shown at right) that can be used once and disposed of. Oxygen connecting tubes and catheters are green so they'll be identified with oxygen use. Also available in plastic, is a non-irritating gastro-intestinal tube.➤



Specifically designed for instrument disinfection is the germicide, Forma-San with G-11. A product of Huntington Laboratories, Inc., Huntington, Ind., and Toronto, Can., Forma-San is said to be effective against tubercle bacilli, spore-formers, and other bacteria. Tests involving two-year immersion of surgical steel and catheters in the germicide, also showed that it was non-corrosive.➤

Nurses, who view bedpan washing as a necessary but unpleasant chore, will welcome the bedpan and urinal washer known as Cyclo-Flush. No hands need be used since foot-pedal operation opens and closes cover, and forearm pressure on a button starts the cycle. A light stays on during the 25-second washing and 30-second steaming period. The model's manufacturer is the American Sterilizer Co., Erie, Pa.➤

JOHNSON'S

Will Not BURN

Non-irritating Johnson's Baby Shampoo possesses other unique attributes and features which commend it for use in both pediatric and dermatologic practice:

1. Backed by exhaustive laboratory tests on animals and by extensive studies in leading pediatric centers.

2. Proven to be non-toxic.

3. Shown to be free of sensitizing

JOHNSON'S

JOHNSON & JOHNSON announces the latest of its famous products especially formulated for babies and children . . .

BABY SHAMPOO

or IRRITATE the Eyes

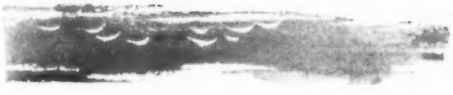
potentialities as evidenced by extensive patch testing.

4. Does not produce excessive drying of the hair or scalp.

5. Extremely bland and mild (pH 7) . . . yet it cleanses thoroughly in both hard and soft water.

6. Leaves the hair soft, lustrous and manageable.

BABY SHAMPOO



What is controversial?

■ A GRADUATE OF one of our leading university schools, recently, in the editor's presence, expressed hesitancy about reading **R.N.** because she had been told it was "controversial."

The incident makes one wonder what *is* the objective of education—to teach people *how* to think or *what* to think?

We are all aware that there are increasing pressures in our society to limit individual thought and expression—pressures demanding a conformity of thinking. Unfortunately, working within our own organizations are also many individuals who, in their misguided enthusiasm, attempt to build fences around the minds of members to keep out unorthodox or "controversial" ideas.

The question of controversy has a special significance to nurses because of nursing's authoritarian tradition—its only-one-point-of-view-permitted type of leadership. The profession is walking too many untrod paths to afford purposeful limitation of thinking among its practitioners.

We have reached a point in our professional development where it is imperative that we stop dismissing unintelligently everything labelled "controversial" and learn to think more discriminately for ourselves.

True controversy is one of our most essential ingredients for growth. Harvard University's president Nathan M. Pusey said in a speech a few months ago that one of the strong traits of Americans has been what he termed their "otherwiseness." But he added that we were fast losing that trait and coming "more and more, not only to think, act, talk, and even look alike, but also increasingly *to want* to do so."

A democratic society or any part of that society cannot exist without an interchange of ideas and opinions. The great growth of

Editorial

From different tones comes the finest tune—Heraclitus

discussion groups implies varying viewpoints. How much more fruitful would be our organizational workshops if expression of all points of view were encouraged rather than identifying one opinion as the loyal opinion.

How in the name of truth can facts be arrived at if true democratic discussion is not encouraged? It is only when thoughtful people with varying viewpoints speak out that we can be reasonably sure of finding a middle ground.

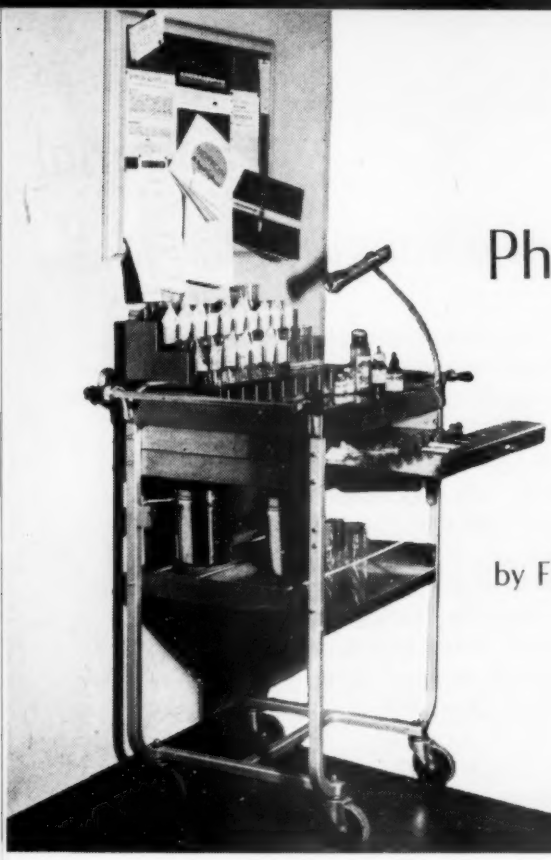
The trend in nursing to enforce conformity of thinking and to label all opposing or non-official ideas as "controversial" is not conducive to growth and development. There is a vast difference between reflective original thinking and unquestioning acceptance of ideas thought out by someone else. One leads to a philosophy of life, the other to a blind alley.

Sydney Hook, chairman of the Graduate Department of Philosophy at New York University, defines science "as a field of continuing controversy which leaves behind it not burning hatreds but vast accumulations of knowledge." Conformity for the sake of conformity does not add to our store of knowledge nor does it stimulate new ideas.

We sharpen instruments by rubbing two opposing edges together. Otherwise, even the finest steel becomes dull. Silver left dormant tarnishes. Apply a little friction and the luster shows through. The abrasive action is only a means to an end. It is the silver that has the real value.

Are minds better for *not* rubbing up against contrary ideas? If a personal idea, or an association's program or platform cannot stand the rubbing against it of varying viewpoints then beware of silverplate passing itself off as sterling.

—Alice R. Clarke, Editor



Pharmacophobia —it's diagnosis

by Frances Lewis Elder

The nurse who returns to the hospital ward after spending some time away from nursing often feels like a woman from Mars. This is understandable, for during her absence a number of changes have taken place in the hospital environment. Even nurses who have worked continuously since graduation find it hard to keep pace with the changing order of medicine.

One of the subjects which has undergone considerable revision in recent years, and which may present a "keeping-up-to-date" problem to active as well as inactive nurses, is pharmacology. With such a bewildering variety of products emerging each year from the laboratories of pharmaceutical houses, it requires continuing study just to learn the names of the drugs, much less their action, dosage, and toxic effects.

That nurses are aware of the need for expanding their knowledge of drugs is evident from the many letters **R.N.** receives from readers asking for information on specific drugs. In fact, it was these inquiries and the results of a reader survey that prompted **R.N.** to introduce its monthly feature of a drug article and *Drug Digest* in 1949. The enthusiastic response to this department over

and treatment

◀Hospitals post literature from pharmaceutical firms in nurses' stations to help keep their nursing staff informed of new drugs. To facilitate administration of drugs, they also provide portable medication carts.

Both the Aloe Dispensa-cart (left) and the Medi-Kar (below) are in operation at Hackensack Hospital, Hackensack, N.J. Patricia Eddy from Ireland, now on the Hackensack staff, is shown using the handy Medi-Kar. ▼

the past five years has more than justified its existence.

Other surveys have led to similar findings. One of particular interest, conducted in a 300-bed hospital to investigate the needs of general staff nurses for an in-service education program, showed that 57 of the 68 nurses questioned were interested in learning more about new drugs. The subject that claimed the interest of the next highest number—46—was "new developments in the care of surgical patients."

Apparently, nurses are well aware that, from the standpoint of patient welfare, they must know more about the numerous drugs they are called upon to administer. This being so, the question naturally arises: What are hospitals, the chief employers of nurses, doing to advance this knowledge? Are they relying on the nurse's intellectual curiosity to find out pharmacological facts for herself? Or are they trying to expose her to as many sources of information as possible?

Since these questions could only be answered through observation and interviews, **R.N.** decided to tour six hospitals and find out for itself if hospitals are acquainting nurses with new drugs, and if they are, what methods they are using to accomplish it. Obviously, this couldn't give an accurate statistical summary of what is going on in all hospitals, but it

could, conducted as it was in different-sized hospitals in both a large city and suburban area, give some indication of how typical hospitals are meeting the challenge of a definite educational need. At the same time, since there is a close relationship between nursing procedures and new drugs, it was also decided to check on noteworthy advances or changes in the administration and care of medications.

It seems that one of the most, if not *the* most, important sources of information about new drugs is the doctor who prescribes the drugs in the first place. This is especially true in those hospitals conducting research with new drugs and in the smaller hospitals where there is more rapport between doctor and nurse. One director of nursing stated that a few of the older doctors don't believe in revealing too much data on drugs but that this possibly stems from their own feeling of insecurity about the newer therapeutic agents. In the main, doctors are only too eager to impart information both in informal conversation and in lectures, and the only criticism leveled at them related to a tendency to talk in a too detailed and technical manner.

It is interesting to note that these findings on the doctors' willingness to have nurses informed about new drugs are corroborated by a far more detailed survey conducted by an independent research company for **R.N.** Out of 372 doctors interviewed for the purpose of determining the physician's attitude toward pharmaceutical advertising directed to nurses, if it were held strictly to an educational program, 54 per cent of the doctors, without qualification, were in favor of such advertising, an additional 17 per cent stated they approved of such advertising *if* it could be held to an educational type of information, and only 15 per cent of the total group were opposed to the idea.

The survey also revealed other significant opinions. To the question, "By what means do you think manufacturers can most effectively provide this educational information?" 70 per cent of the doctors mentioned nursing journals; 25 per cent said mailed literature; 16 per cent said salesmen; and 16 per cent were in favor of conducting clinics and exhibits for nurses. The two most frequently mentioned points that doctors believed should be included in this advertising were toxic symptoms and side effects, and action of the drug. When asked whether nursing journals should include a scientific section on new therapies, 80 per cent of the doctors questioned were in definite agreement.

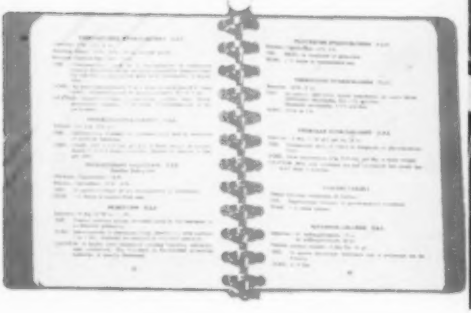
The hospital pharmacist is naturally regarded by all professional personnel as an authority on the standard as well as the newer drugs. It is he to whom nurses turn when in doubt about a prescribed dose, or when it is not convenient to get information on a certain drug from the doctor.

In all six of the hospitals visited, there appeared to be good relationships between the pharmacist and the nurse. And in five of these hospitals,

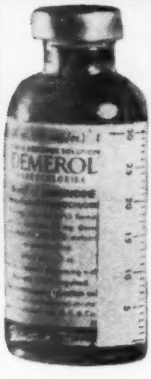
R.N. VISITS MOUNTAINSIDE and HACKENSACK HOSPITALS

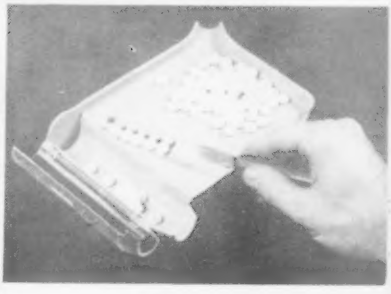
Accuracy, as well as knowledge of drugs, is a "must" in giving medications. Constance Crosbie (role-playing a once inactive nurse) is supervised in this procedure by head nurse Barbara Beldin (right) at Mountainside Hospital, Montclair, N.J.

Good nurse-pharmacist relationships (shown above by Evelyn Gundersen and pharmacist Anna C. Richards of Mountainside Hospital) mean a lot nowadays when nurses rely heavily on hospital pharmacists for the latest drug data. Besides seeking information from the pharmacist and doctor, busy nurses such as Barbetta Tyson of the Hackensack Hospital (right) can often find facts in the hospital formulary, especially if it is like the formulary available at Hackensack (below).



Strict narcotic controls are the aim of hospitals which require nurses to count narcotic drugs at the changing of shifts. Devices to speed up this procedure include a plastic counter from Abbott Laboratories and a measuring sticker supplied with bottles of Demerol by Winthrop-Stearns, Inc. Both are used at Mountainside Hospital where narcotics and hypnotics are kept under double lock in cabinets designed by Lucie R. Ennis (left), assistant director, nursing service.

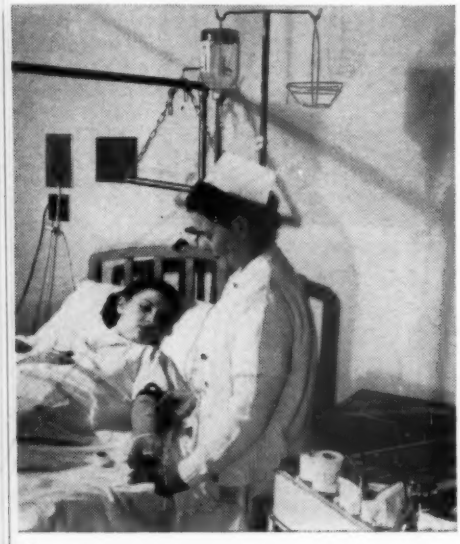




the pharmacists are assuming responsibility for teaching nurses about new drugs. At one hospital, the pharmacist gives a lecture on new drugs every two or three months at staff conferences. Mimeographed sheets of the material covered in the talk are carried back to the wards for reference. Another helpful method of keeping ward personnel posted on new drugs is the routine observed in one hospital of sending bulletins on the latest drugs to the wards at regular intervals.

Only one pharmacist of this hospital group teaches nursing students pharmacology, although at another hospital, the pharmacist conducts a two-hour orientation period for affiliating students. Whether the hospital pharmacist should teach pharmacology in nursing schools, seems to be a moot question. Two of the six hospitals have discontinued this practice, believing the subject can best be taught by the science instructor, who can devote more time to teaching. One reason advanced for having the pharmacist teach pharmacology to students is that it makes for a closer understanding of the problems encountered in both the nursing and pharmacy departments of the hospital.

I. V. nurses like Anna B. Landis of Hackensack Hospital lighten doctors' and nurses' duties by administering intravenous fluids.



Invariably, it was found that pharmacists in these hospitals rely heavily on the literature of pharmaceutical manufacturers to inform nurses of new drugs. Advertising blotters, leaflets, and exhibit material are sent to the wards and nursing offices where they are posted on bulletin boards, and in some cases, are presented to students in pharmacology classes. This material is used solely for educational purposes. For example, when *Achromycin*, a new antibiotic, came into general use, hospital pharmacists wanted to be sure that nurses distinguished it from *aureomycin*. To make them more familiar with the new but similar name, advertising blotters imprinted with *Achromycin* in large letters and bright orange coloring were sent to each ward and placed on the nurses' desks so they'd be in constant view.

The nursing department, as well as the pharmacy, is also finding new ways of utilizing the material put out by the drug houses. One nursing service director, after seeing a file box of drug cards issued by a well-known firm, asked a sales representative for fif- [*Continued on page* 61]

CANDID COMMENTS: *The Long View*

■ IN FEBRUARY we stated that one of the marks of a profession was an awareness by the majority of its practitioners of its place in the service of society. The importance of this awareness demands elaboration. Some of our patients are getting the best care in the history of professional nursing—and some are getting the worst. Some nurses have a grasp of the depth and nature of nursing's problems; others are confused and disaffected. We have achieved structural unity in our professional associations, yet the gaps in many of the ideas of nurses have never been so wide. No matter what projects we promote for improving the lot of patient and nurse, the great contrasts and deviations in patient care and nurse morale cannot be resolved until the majority are more united in understanding.

Janet M. Geister, R.N.

In a thought-provoking article, *The Healer and the Scientist*,* Dr. Dana W. Atchley points out that "the old art of healing has at last been fused with the young science of medicine." The full implications for nursing of this merger of the old art with the new science are not quickly comprehended, yet at base they account for much of our situation. The fusion is not quick or dramatic. Nor is it clear cut. The movement is ponderous; it threatens cherished customs; it outmodes illogical traditions. It brings heartache to the old practitioner, often imbalance in the preparation of the new one—and headaches for every one concerned.

Such by-products of change are inevitable, but they can be turned into constructive thinking and gains for all instead of destructive emotion with losses for many. The fusion of the old art of healing with the new science of nursing—while much of nursing education is still dependent upon hospital economics—has brought large, new problems. The demand for nursing care far in excess of our present resources has brought other large problems. The nursing care of today must cover a broader variety of needs than those of yesterday, and it must be applied in much more varied form. The rigid, conforming disciplines of the past must be replaced by new ones that develop the *nurse* as well as her practices.

In my early days of nursing, the majority of our patients were desperately sick or surgical cases—and surgery of those days was an event, not an episode. Our battles against pneumonia, typhoid, puerperal

*Saturday Review, Jan. 9, 1954.

septicema, peritonitis, et cetera, were mainly grim struggles of nurse versus disease. We applied plasters and compresses; we injected normal salt solution; we gave "hypos," but very sparingly. We sat alert hour by hour, watching changes in the patient's color, pulse texture, breathing. We had to *anticipate* then, for we had none of the magic diagnostic and restorative aids of today.

The patient's nursing needs of those days were met almost wholly by products from within the nurse herself. We fought from our hearts out, and I still believe that we carried many a patient through his crisis successfully by the sheer power of our wills. It was the art of nursing at its best.

Today's patients still demand the nurse herself, but the nurse *plus* the new instruments and new medications of science. This calls for greater technical skills, wider knowledge, and a division of patient-side duties that shows professional nursing off to its greatest advantage. Today's patient-needs represent many different phases of a broader variety of disease and accident. The need for intelligent observation is just as great but it needs to be applied in different doses and in different areas. The objective today is not only to forestall death but to restore and rehabilitate, and to promote health. In the old days we generally knew the economic and social problems of our patients, and their mental attitudes, but we had neither the time nor opportunity to apply this information to a plan for the patient. Today, such planning is the ideal we strive for.

While today's nursing differs in its skills and applications from that of the past, one thing is unchanged—patients still need nurses. Every one of them needs *something* from the nurse, if it is only "how are you this morning?" I don't believe anything is more distressing to all concerned than what is revealed in the oft-repeated statement: "I was in the hospital five days and rarely did I see a nurse." Whoever *willingly* devises plans that interfere with the nurse-patient relationship is not only blocking traffic but directing it to the wrong road.

"The synthesis of the healer and the scientist," writes Dr. Atchley, "has produced two outstanding changes in the practice of medicine: the healer has guided us back to a primary occupation with a person, an individual human being, and the scientist has given us the power of analysis and integration." So is it with nursing. The "old art of healing" must be blended with the "new science" of nursing. The healer and the scientist must be fused, but one is never a substitute for the other. Science is cold and precise; it measures the patient's condition but never the patient. The warmth of nursing rises from its art, and every human service must have warmth. The compassion, the "feel for patients," the ability to observe more than the eye can see or the instrument record, are integral elements of the art of nursing. They must underlie the science, or we develop a

form of hybrid nursing, incapable of reproducing itself.

The enthusiastic swing to the sciences brought losses in the art of healing in nursing as in medicine. There are always losses in such fusions, but in fields so earnestly dedicated to human welfare, we are always "guided back" to recapture the tested and enduring values. Our losses have been accentuated because too much of our care today is geared to hospital rather than patient needs.

Nursing is working in many areas to find its right place in patient care. The "functions" studies now being pursued by various branches of practice will reveal what are present practices. We can hope they will lead to a comprehension of what these practices *should be.* The experiments in team nursing surely will provide some substantial answers not only regarding administration of nursing service, but also when, where, and how it should directly touch the patient. Nurse educators work constantly to fit their programs to the changing needs. Education in any dynamic field must ever add, subtract, modify or expand subject matter and method, according to new needs and knowledge.

I wish most earnestly that more research [*Continued on page* 69]

Probie

"I should know that's how he means no more!"

■ THE NURSING supervisor is in a position somewhat similar to that of the middleman in the field of commerce—the person who sees to it that the producer's goods are relayed to the retailer, who then serves the customer. In like manner, it is the responsibility of the nursing supervisor to see that the products of administration, such as policies and procedures, are relayed to the staff nurse, who, in turn, serves the patient and his family.

If the consumer is not satisfied with the merchandise, word is passed to the producer and necessary changes are made. Similarly, if the policies governing the services to the patient do not meet his needs, the staff nurse tells the supervisor who, in turn, informs administration. Administration can then make the changes necessary to improve the situation.

The basic principles which apply to nursing supervision are the same as those employed in any other situation involving a worker-supervisor relationship. The same problems of human relations arise in nursing that arise in any field of service to the public, and the role of the nursing supervisor is like that of supervisors everywhere in that it demands a dual responsibility. The nurse-supervisor interprets the policies of the agency or hospital to the staff nurse and the reactions of the staff nurse to hospital or agency administration.

Inasmuch as the supervisor is also a teacher, she must be aware that

learning patterns differ in both pace and content for each individual. She may have a *group* of nurses under her direct supervision, but her thinking and teaching must be geared to the concept that each *member* of the group is an individual with a particular set of emotional qualities which may become assets or liabilities—depending upon the type of supervision received. The supervisor should not only be able to recognize the nurse who is working under pressure, but she should also have the ability to help that nurse work

Nursing's Middleman—the supervisor

by Emma Harling*

out her problems. No individual can grow and develop when working under pressure, whether that pressure comes from within or without her working environment.

The supervisor has been defined as a person endowed with certain qualities of leadership, who also has experience in the field, and professional knowledge which enables her to be responsible for the training and guidance of those less well equipped. Along with these qualifications should be added the ability to work with others and to relate to and understand the nurse as a person in such a way that those whom she supervises may obtain satisfaction in their work.

Sometimes a supervisor may fail to see the staff nurse where she is—that is, she may fail to recognize at which particular stage of development the nurse has arrived—and then she may feel a keen disappointment when the nurse in question is unable to reach the professional heights expected of her. The interim period necessary for growth is longer for some than for others, and the supervisor who realizes this will not believe, in such a case, that she herself has failed as a teacher. The supervisor needs to understand human reactions to the learning process and to be cognizant of the many difficulties which beset the individual nurse in relation to the situation in which she finds herself. Many nurses resist supervision because of unconscious conflicts within themselves, possibly stemming from an earlier experience seemingly forgotten. They may unconsciously project these feelings on to environmental factors over which they have no control.

Some consider the development of the nurse's professional self to be the chief concern of the supervisor. Although this term has been used a great deal, it is debatable as to whether the main objective should not rather be to develop the potentialities of the whole self, by helping

*Mental Health Nursing Consultant, Colorado State Health Dept.

every nurse to recognize her own needs, capabilities, and limitations, and to guide these potentialities into professional channels. Unless one's whole self takes part in the learning process, the results are unsatisfactory to the nurse and to the profession. It is necessary that a good professional relationship be maintained, but often that relationship has been so overly professional and so utterly impersonal that it has resulted in a rigid inflexible performance of duties by a tense, anxious person with superbly controlled emotions. The ideal relationship is personally professional—not socially personal. There is a great deal of difference between the two. The more the supervisor can relate to the nurse as a person, the more that nurse will feel that she is a contributing member of a team —not just a cog in the wheel of a smoothly running machine.

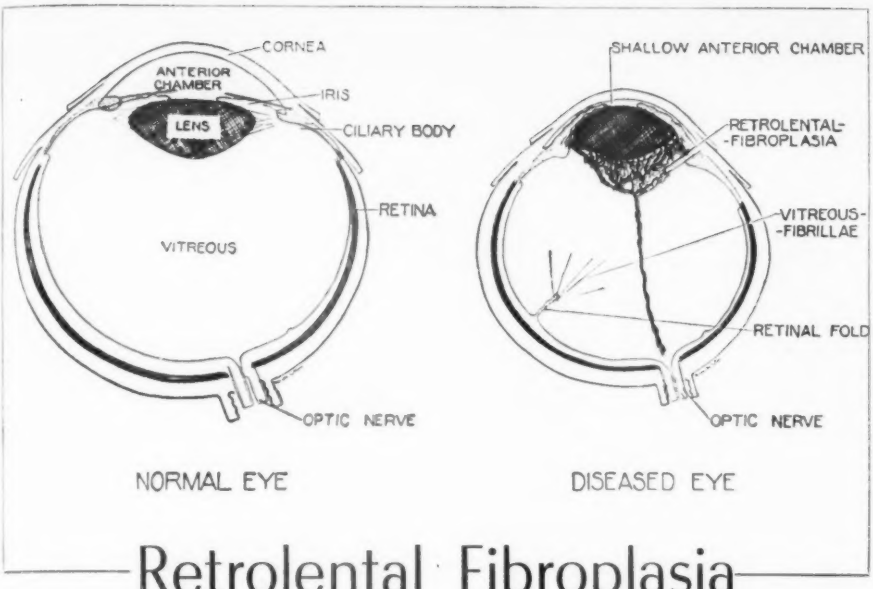
As a liaison person between staff and administration, the supervisor should have first-hand knowledge of the nurse's patient load as well as of the overall organization and planning of the agency for which she works. One of the tasks of the supervisor is to evaluate the work of her staff, a task which many supervisors dislike and put off until the last possible minute. Difficulties in this area stem from a general disinclination to "criticize" another person. Actually, a progress record showing steady growth is of far greater value than a final evaluation which rarely meets the standards set up for the "ideal" nurse. If the nurse, through her relationship with her supervisor, has learned to evaluate her own work, a valuable teaching tool will result. It is a good plan to ask occasionally for written reactions to the learning experience on the part of the staff nurse. Many excellent ideas have been elicited in this manner.

Acting the part of middleman has its compensations. The nursing supervisor does not have the burdens of administration nor the first-hand frustrations of the staff nurse who works directly with the patient. She knows that if she, herself, is a warm, understanding person who recognizes her own human assets and liabilities as well as those of individuals under her guidance, she will earn the confidence and respect of both staff and administration. What more could any middleman ask for?

Advice

Consider well the words you utter,
Make them good, don't fail to sweeten,
Spread them with a little butter,
Just in case they must be eaten.

—*Frances Gibson, R.N.*



Retrolental Fibroplasia

A major and relatively new cause of blindness in children

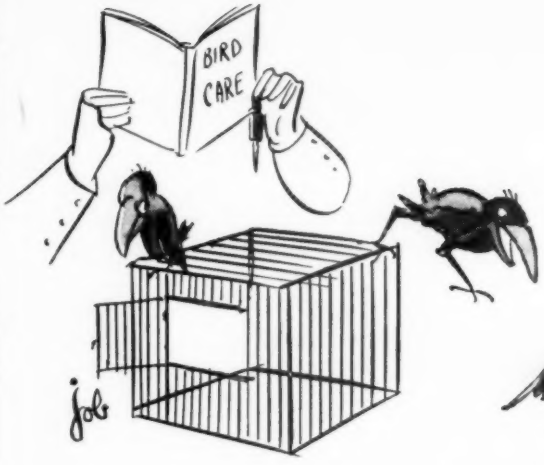
by Harry and Mary Ernsting*

■ A NEW DISEASE of major concern to all who care for premature infants has made its appearance within the last fifteen years. Known as retrolental fibroplasia, this disease attacks premature infants and may cause total and irreversible blindness.

A neovascular disease of the retina and vitreous, retrolental fibroplasia is being reported with increasing frequency, and is most often encountered in infants who weigh less than four pounds at birth. Since 1942, when the disease was first described, it has become recognized as a major cause of blindness in children. Fortunately, all premature infants do not develop this disease. Conservative estimates show that roughly 25 out of 100 premature infants are found to have retrolental fibroplasia.

The disease starts in the retina and spreads to the vitreous—the substance lying between the retina and the lens. It arises in the nerve fiber layer of the retina where nests of endothelial cells and glial tissue thickenings appear. This tissue becomes vascularized; edema and hemorrhage occur and the tissue breaks through the limiting membrane of the retina. Masses of tissue grow between the hyaloid membrane of the vitreous and retina and finally break through into the vitreous itself. Once the vitreous is invaded, the invading

*Dr. Ernsting and his R.N. wife enjoy writing together on medical subjects.



"Zeke & Dessie"

mass can become organized and contract. Folding and detachment of the retina, secondary glaucoma, lenticular and uveal changes, and other serious complications may occur. Blindness may be the final result.

Up to the point where the vitreous is invaded, most authorities believe that the disease can stop and regress to almost normal, especially if treatment is given. Although certain investigators believe that some degree of regression is possible even after the vitreous has been invaded, others consider such a feat impossible. All agree that regression is impossible after the retina is detached.

At one time it was believed that one eye only could be involved. But most authorities now think that retrolental fibroplasia is always bilateral, although one eye may be involved before the other.

What, one cannot help but ask, is the cause of this devastating disease, and why has it not yet been controlled? The answer is, to say the least, disappointing. Since the disease was first described, it has defied the best efforts of every investigator to detect its cause or to control it.

Theories concerning the possible causes of retrolental fibroplasia abound, ranging from those dealing with developmental defects to those dealing with faulty oxygen relationships. No theory fully satisfies, but the one dealing with oxygen relationships is the one currently receiving the most attention. Those in-

vestigators who consider oxygen to play a leading role warn that the administration of high oxygen concentrations to prematures must be followed by a gradual withdrawal or weaning from such concentrations. Others having similar ideas go a step further and use oxygen only when it is absolutely necessary to save life. Theories regarding other possible causes such as diet, light, hygiene, environment, and the physical condition of the mother and child have all been rejected.

The diagnosis of retrolental fibroplasia can be made only upon examination of the interior of the eye with an ophthalmoscope. It seems logical that every premature infant should be given such an examination periodically. Because the fundus of prematures differs in appearance from that of adults, and because remnants of pupillary membranes and retinal hemorrhages are seen in a small percentage of normal prematures, even when retrolental fibroplasia is absent, it is important that the examinations be carried out by an ophthalmologist or some other qualified person. The disease rarely begins before the second week or after the third month from birth consequently, the periodic examination may be safely confined to this time interval.

The earlier the disease is discovered, the greater is the chance of successful treatment. However, it must be admitted that treatment is not too satisfactory in any case, although pathological changes which have taken place may undergo almost complete reversal if treatment is begun before any retinal detachment occurs. Serious residual effects such as atrophy of the optic nerve or atrophic changes in the fundus may persist, however. If prematurity itself could be prevented, it is likely that the disease would disappear, for it is thought that the closer a fetus can be brought to full term the less likely [*Continued on page* 70]

Photos: Courtesy of Great Northern Railway

BLOOD CENTER ON RAILS

■ ALTHOUGH THE nurses in St. Paul's Regional Blood Center nominally work in Minnesota's capital city, their scope of operation takes them over much of the central Northwest. One reason for this is that the Red Cross headquarters in that city, in conjunction with the Great Northern Railway, operates a "blood center on rails." Called the Red Cross-Great Northern Blood Procurement Car, the novel unit had, at the end of 1953, rolled up some 14,750 miles in Minnesota, the Dakotas, and in Wisconsin.

"I've been on the car three times now," said Myrna H. Adam, "and I'm looking forward to going on it again. You see, all the nurses at the center have to spend four weeks 'on the railroad.' It's just part of our job. Since there are only twenty-nine nurses, it means most of us get several chances. Frankly, I find it an unusual experience and one which gives me a great deal of satisfaction."

Miss Adam's comments are typical. The job is unusual, and the acceptance of the procurement car has been gratifying. Since the unit was put into service in April of 1952, 23,996 pints of blood had been donated by the end of 1953. The initiative came from the railroad, which offered to provide the car free of charge to the American Red Cross for operation on the Great Northern system. This offer was enthusiastically accepted. An observation lounge car was completely remodeled for this purpose and christened *Richard Vincent Whalen* in honor of the first Great Northern em-

Prospective donors are interviewed and examined in the blood procurement car's waiting room. Frances McGowan checks the blood pressure of a would-be donor while other volunteers await their turn.

Mrs. Amelia Swenson, deputy chief nurse, assisted by a Gray Lady, staffs the collection room of the blood procurement car. This room, in the center of the car, accommodates as many as four blood donors.

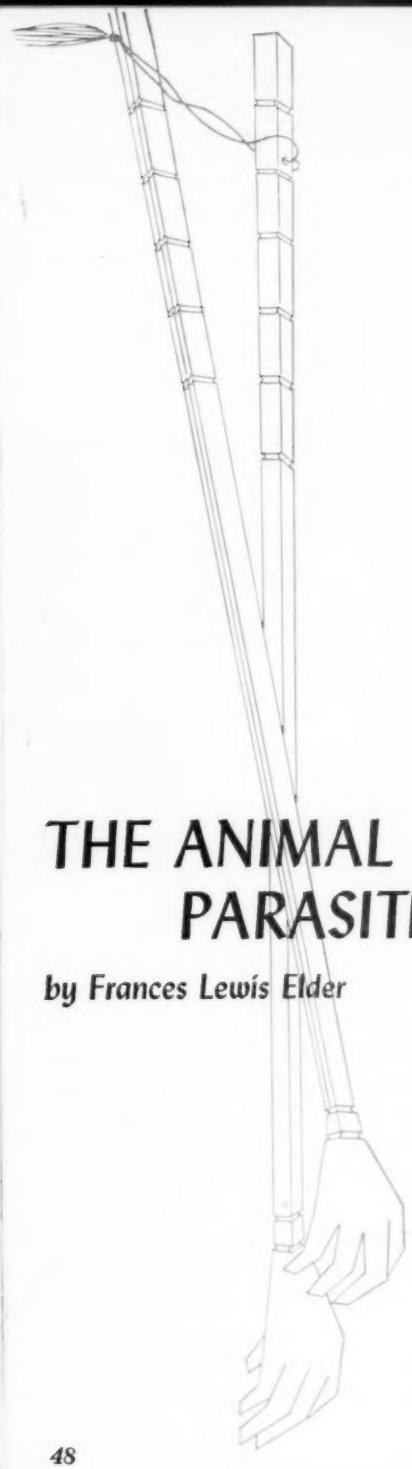
Boarding the Red Cross-Great Northern Blood Procurement Car preparatory to its departure from St. Paul, Minn., is its staff of nurses: (left to right) Gertrude Mountain, Amelia Swenson, Rosemary Conlin, and Frances McGowan.

by Frank P. Donovan, Jr.

ployé to lose his life in the Korean War. Within the car, the rear lounge serves as a waiting and interviewing room for blood donors. A large collection room at the center is equipped with four beds built to Red Cross specifications. Another lounge at the opposite end serves as a canteen, where donors receive a light snack before they leave.

The regular staff on the car consists of four nurses, one of whom is an acting chief nurse, and an attendant. The attendant is provided by the railroad. Usually the personnel put up in hotels for the night but when the car is in transit they sleep in berths on the vehicle. The volunteer staff is by far the largest and is recruited at communities along the way. The full complement includes a physician, three nurses' aides, a Gray Lady, three typists, two canteen workers, and a nurse for the canteen and recovery room.

While the movement and the servicing of the car is left to the railway, all other details are in the hands of the chief nurse. She must see that everything is carried out on schedule. Sometimes the unit will remain in a community for several days or a week; not a few hamlets are just "one night stands." Drawing blood is limited to six hours a day and the remainder of the time is given to getting the [*Continued on page* 59]



THE ANIMAL PARASITES

by Frances Lewis Elder

■ AMONG THE MEDICAL conditions not generally alluded to in polite conversation are scabies and pediculosis. Probably the chief reason for avoiding these subjects, aside from the unpleasant appearance of the diseases, is their association with dirt and squalor. And it is true that these afflictions are found most frequently among those who are not too well acquainted with the benefits of soap and water. However, it is also true that even those who boast the best hygienic habits may sometimes be affected by scabies and pediculosis because of the contagiousness of these troublesome skin diseases.

The parasites responsible for scabies and pediculosis have apparently affected people for centuries. Scabies, at least, was mentioned in early medical writings, and in the Middle Ages it was reported among the eight common diseases. Despite the great progress made in sanitation and the medical sciences, both diseases must be considered public health problems today.

The two types of parasites, which are frequently found to accompany each other, seem to thrive best under wartime conditions. It is reported that during World War I, scabies and pediculosis accounted for 90 per cent of the sickness in the British armies. It was in this same war that the louse acquired widespread recognition under the name of "cootie." In World War II, although pediculosis was largely controlled by the insecticide DDT, its companion disease scabies once more reached epi-

demic proportions, affecting both civilians and the military.

Scabies, the skin disease that is sometimes referred to as "the itch" or "seven-year itch," is named from the Latin word *scabere*, which means to scratch. The causative organism, a minute animal parasite, is now called Sarcoptes scabiei, but was formerly known as Acarus scabiei. Although it is impossible to detect this parasite with the naked eye, since the female mite measures from 0.25 to 0.33 mm., and the male is about half that size, one may be able to see evidence of the tunnels or burrows which the impregnated female mites leave in their wake as they travel along the horny epidermis of the skin depositing their eggs. These burrows appear as thin black lines about one-eighth inch in length. Each day, the mites lay two or three eggs which eventually hatch, emerge from the burrow, and enter the hair follicles.

Further evidence of scabies is found in the location of the burrows and the lesions that accompany them. The female mite prefers the thin-skinned areas of the body for her safaris, such as the extensor surfaces of the elbows, the flexor surface of the wrist, the axillary folds, the waistline, the inner surface of the thighs, the genitals of the male, and the female breast. In children, however, the webs of the fingers and the creases of the palms may be additionally affected, and in infants the soles of the feet, the scalp, and even the face may be infested.

The most annoying symptom of scabies—an intense itching—arises from the dermatitis which may include papules, pustules, crusts, excoriations, and hyperpigmentation. The itching is most intense at night because the warm environment of the bed seems to encourage wider activity of the parasites. Occasionally, the primary eruptions become complicated by the secondary lesions of impetigo, boils, or eczematoid dermatitis.

Transmission of scabies depends more on intimate than on casual contact, therefore, it is not uncommon to find the disease rampant in the same family, and in other closely-knit groups attending schools or residing in barracks and camps. Sleeping with an infected person or in a contaminated bed is one way of acquiring the parasites, but the disease may also be transmitted through the use of contaminated towels and clothing.

In the past, the traditional scabicide has been some form of sulfur. But today, in addition to sulfur, physicians can prescribe other drugs that offer prompter and, in many cases, more effective results. The scabicides accepted by the American Medical Association Council on Pharmacy and Chemistry and described in *Drug Digest*, page 50, can generally effect a cure of the disease after one or two applications if instructions are followed carefully. Nevertheless, a complete cure will depend not only on the type of scabicide employed but on whether the patient cleanses himself thoroughly before treatment [*Continued on page* 73]

Drug Digest

CHLOROPHENOTHANE U.S.P. (Insecticide)

PRODUCT NAMES: Distributed under official name or as DDT.

PHARMACOLOGY: This drug, which is now widely recognized as an effective insecticide capable of destroying many types of insects, is also employed in the treatment of pediculosis and scabies. It is included as a primary ingredient in the *N.N.R.* mixture, benzyl benzoate-chlorophenothane-ethyl aminobenzoate, because of its specific action of killing lice. In addition, this mixture contains benzocaine, an ovicide, and benzyl benzoate, a scabicide and, to a lesser extent, a pediculicide.

DOSAGE: DDT has been used extensively as a louse powder. The *N.N.R.* preparation containing DDT is applied in pediculosis either as an emulsion or as an ointment. After being well rubbed into the hair and scalp of the involved area, this mixture should remain for 24 to 48 hours and then should be removed with soap and warm water. In scabies, a liquid emulsion or ointment is rubbed over the body surface below the neck after a warm, soapy bath. The patient should not be permitted to bathe for at least 24 hours after application. Care should be taken that all clothing and bedclothes are dry-cleaned or laundered.

UNTOWARD ACTIONS: The mixture should not be applied near the eyes or mucous membranes. It has been noted that DDT has infrequently produced allergic eczematous dermatitis on repeated contact with the skin. DDT in powdered form is not as likely to produce toxic effects as it is when incorporated in oil or oil-miscible solvents. Its cumulative action and absorbability from the skin, however, is hazardous. The victim of DDT poisoning may complain of a feeling of heaviness, aching of limbs, weakness of legs, and nervous tension. Several fatalities have occurred from toxic dosage.

BENZYL BENZOATE U.S.P. (Scabicide)

PRODUCT NAMES: Benylate, Vanzoate

PHARMACOLOGY: Benzyl benzoate, an oily liquid with an aromatic odor and sharp, burning taste, was originally employed in medicine as an antispasmodic. Now classified as an effective scabicide, it is incorporated in lotions or emulsions for external application in scabies. It may also be used topically in cases of pediculosis that are complicated by scabies. In proprietary preparations, benzyl benzoate may be combined with DDT and benzocaine.

DOSAGE: The concentration of benzyl benzoate in emulsions or lotions ranges from 10 to 30 per cent. Preparations are applied with a brush or swab over the whole body surface, except the face, while the skin is damp after scrubbing lesions in a 10-minute bath in soap and warm water. A second application is made to the affected areas following the drying of the first application. At the end of a 24-hour period, the patient takes a warm soaking bath and puts on clean clothes. Both bed and body clothing should be sterilized.

UNTOWARD ACTIONS: A slight burning sensation of momentary duration is occasionally noticed after application of benzyl benzoate and persons with sensitive skin may experience severe skin irritation. Care should be taken that the drug never comes in contact with the eyes.

GAMMA BENZENE HEXACHLORIDE N.N.R. (Scabicide, Pediculicide)

PRODUCT NAMES: Gexane, Kwell.

PHARMACOLOGY: Classified as both a scabicide and pediculicide, gamma benzene hexachloride is one of the comparatively new agents used to combat the parasites involved in scabies and pediculosis. As an insecticide, it has been reported to be more rapidly effective in lower concentrations than DDT.

DOSAGE: Gamma benzene hexachloride, in concentrations up to 1 per cent, is administered externally in the form of a lotion or ointment. The lotion or ointment is applied directly to the involved parts of the skin or hair as well as to the adjacent non-involved parts in order that treatment may be effective. Generally, single treatments consist of not more than 30 cc. of the gamma benzene hexachloride preparation. In treatment of the scalp, a small brush may be used to spread the ointment or lotion, and a towel is worn over the head for one hour after application. In some cases, the hair of female patients may have to be cut before application. After treatment, the body, including the hands or hair, should not be washed for at least 24 hours. A second application may be made after one week, should the first fail, but it is advised that the drug not be administered more than three times in order to avoid skin irritation. As in other forms of treatment, clothing and bed linen should be sterilized as a precautionary measure against reinfection.

UNTOWARD ACTIONS: The drug is irritating to the mucous membranes and must not be used near the eyes. Because of its toxicity and the possibility of its being absorbed through the skin, it should always be used under medical supervision.

ISOBORNYL THIOCYANOACETATE-TECHNICAL N.N.R. (Pediculicide)

PRODUCT NAMES: Bornate

PHARMACOLOGY: Isobornyl thiocyanoacetate-technical, a yellow, oily liquid with a terpene-like odor, is one of the thiocyanates that is effective as a pediculicide. Mixed with dioctyl sodium sulfosuccinate in the form of an oil emulsion, it is used topically to kill the ova and adult forms of Pediculus humanus capitis, Pediculus humanus corporis and Phthirius pubis.

DOSAGE: The oil emulsion, consisting of 5 per cent isobornyl thiocyanoacetate and 0.6 per cent dioctyl sodium sulfosuccinate, is administered externally in amounts ranging from 30 cc. to 60 cc. When the scalp or body is treated, the compound is worked into a lather and allowed to remain on the affected area for 10 minutes. The hair is then combed with a fine-tooth comb and washed with bland soap and water. The emulsion is rubbed well into the hair on the body and also washed off with soap and water.

UNTOWARD ACTIONS: Although this pediculicide may act as a mild primary irritant, it does not appear to act as a sensitizing agent. The emulsion should not remain on the skin too long, nor should more than two applications of the type described above be made. It should never be applied near the eyes or to the mucous membranes.

News in Review

▶ *REJECTION OF THE ANA PLEA* to extend the National Labor Law to nonprofit hospitals was the House Labor Committee's first decision in regard to the revision of the Taft-Hartley Act. The Committee voted 14 to 9 against the extension of the law. ANA is desirous of having nonprofit hospitals placed under the jurisdiction of the National Labor Law for the purpose of forcing the administrators of nonprofit hospitals engaged in interstate commerce to bargain collectively with the state nurses association when requested. Actually, only a very small percentage of nonprofit hospitals in the U.S. are engaged in interstate commerce.

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▶ *ADDITIONAL GRANTS OF $80,743 FOR NURSING RESEARCH* projects in six states are to be made by the ANA. Sixteen grants, totaling $135,208 were made through 1953. The projects to be undertaken will include a study of graduate nursing in the obstetric service of a New York Hospital. Initiated in 1950, the program was originally financed by the voluntary contributions of nurses, but it is now paid for out of ANA membership dues.

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▶ *A CLINIC FOR THE AGED*, reportedly the first of its kind, has opened at Beth Israel Hospital, New York City. The new clinic proposes to fit the aged into the community social life and help them gain financial independence, as well as to treat their physical ailments. Dr. Louis Friedfeld, director of the clinic, states that there is no such medical diagnosis as "old age." All incoming patients will receive a complete medical examination including psychiatric evaluation. Also, research will be done concerning their social and economic problems. Although only a limited number of patients will be accepted each week, it is hoped that as many as 200 may be taken care of by the year's end and that, in ensuing years, the total will continue to rise.

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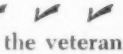
▶ *NATIONAL NURSE WEEK* will be observed October 4 to October 9, 1954 if House Resolution 359, introduced by Rep. Frances Payne Bolton, (R-Ohio) is passed. Falling on the 100th anniversary of Florence Nightingale's notable work in the Crimea, National Nurse Week

will honor the professional nurse of America. Mrs. Bolton states that National Nurse Week will provide an opportunity to interpret nursing more fully, serve as a foundation for a variety of community action programs throughout the nation, stimulate student nurse recruitment, and dramatize the service which nurses are performing in all types of health and hospital programs. To coordinate the observance of the week, Mrs. Bolton's resolution would set up a Central Council of which Mrs. Oveta Culp Hobby, secretary of the Department of Health, Education, and Welfare would act as chairman. Representatives of the President, Congress, Surgeons General of the armed forces, the Advertising Council, the American Hospital Association, and various nursing organizations would serve as members of the Central Council.



▶ *MORE THAN HALF* of all the veterans who served in World War II have received training through the G.I. bill since June, 1944. In all, 7,800,000 veterans took advantage of the educational provisos of the bill. At the peak of the program, in December 1947, some 2,500,000 veterans were enrolled, although, at present, enrollments are only up to one-eighth of this record figure and are continuing to drop.

▶ *PRESIDENTIAL GREETINGS* were received by the Army Nurse Corps on the occasion of its fifty-third anniversary, February 2, from President Eisenhower. This is the first time in its history that the ANC has received an anniversary message from the President of the United States. President Eisenhower wrote:

"My warm congratulations go to all members of the Army Nurse Corps on the occasion of this fifty-third anniversary.

"Today, when members of our armed forces come from so many American households, millions of our fellow citizens can find comfort in the knowledge that the trained nurses of the United States Army give superior care to our sick and wounded soldiers. This is one more

About People

▶ The Medal of Freedom, highest award of the U.S. Army to be conferred upon a civilian, has been presented to *MRS. NADINE ROBINSON* in recognition of her work at Severance Hospital, Seoul, Korea. (See *R.N.*—May, 1953). *EMMA EIG*, formerly director of nurses, Miriam Hospital, Providence, R.I., has been named director of nursing service in the new Long Island Jewish Hospital, New Hyde Park, L. I. . . The first women ever assigned to military duty north of the Arctic Circle are *LT. CHRISTINE STEVENS, LT. HELENA COSTA*, and *CAPT. S. M. SCHADT* who are stationed at Thule Air Force Base, Greenland . . . *MRS. ESTELLE M. OSBORNE*, formerly an assistant professor at New York University, has joined the staff of the NLN as assistant director for general administration.

reason why all who participate in the work of this splendid Corps can take pride in its accomplishments.

"I am sure that in the coming year, as in years past, the young women of America will join you in your humanitarian work, adding steadily to the reputation of your Corps as they not only serve our armed forces, but prepare themselves for added service to members of their home communities upon return from military duty."

▶ THE THEME of World Health Day, April 7, will be, "The Nurse—Pioneer of Health." Special celebrations to be held throughout the world will stress the role of the nurse in international health. At present, there are about 140 nurses of twenty-two different nationalities working in thirty-one countries on various projects of WHO.

▶ FOR THE RECRUITMENT of student nurses a new film, "When You Choose Nursing," portrays the work and recreational opportunities of nurses in pediatrics, teaching, industry, and public health. Betty Bowles, pediatric nurse from Mary Hitchcock Memorial Hospital, Hanover, N.H., plays the leading role in this 16 mm. film which has a running time of 20 minutes. Produced under the direction of the Committee on Careers, National League for Nursing, the film was financed by Lederle Laboratories, Division of American Cyanamid Company and was made by Willard Pictures. Distribution plans call for showings arranged through state and regional Careers Committees. "When You Choose Nursing" may be purchased for $35 or rented at $4.00 for three days through the Committee on Careers, National League for Nursing, 2 Park Avenue, New York, N.Y.

▶ TO HELP MEET the medical needs of southern and central New England, plans are now underway for the development of a Yale-New Haven Medical Center to be patterned on New York City's Columbia-Presbyterian Medical Center. Yale Medical School and Grace-New Haven Community Hospital will serve as integral parts of the Center, although each will keep its independent corporate status. The University is making available its School of Nursing, Psychiatric Institute, Department of Public Health, and Child Study Center. Hiram Sibley, executive director of the Connecticut Hospital Association, has been appointed director of the program for the development of the proposed, new Center.

▶ PRIVATE DUTY FEES: Extra compensation clauses have been dropped from the minimum standards for private duty nurses in Minnesota. The clauses provided that private duty nurses receive $2 extra per shift when caring for a mother with baby, or for alcoholic, contagious, tuberculous, drug addiction, mental and nervous patients or for patients with polio during the isolation period. At present, private duty nurses in [*Continued on page* 76]

Calling All Nurses

Children's Hospital, San Francisco, Calif., alumnae: We're planning a reunion on May 8. Please send your name and address to me so I can send you details about the celebration. Mrs. Marcella Murphy, 438 24th Ave., San Francisco 21, Calif.

Lilly Schimmel, formerly of Chicago: I'd like to get in touch with you. Please write to me. Mrs. Cecile Lefebose, 76 Kinsley St., Nashua, N. H.

Christ Hospital, Rochelle Park, N.J., alumnae: We're holding open house on Saturday, April 24 in the nurses residence as part of our 65th anniversary celebration. Please send your name and address to me so I can tell you all about it. B. Helen VandenBerg, Christ Hospital Alumnae, 48 Colling Ave., Rochelle Park, N.J.

Alma Lewis, Jeannette Loomis, Carol Maltke, Hazel Nyhus, Mary Agnes O'Keef and **Frances E. Vercusky:** We have received keys belonging to you. Please send your present mailing address to **R.N.**'s editorial department so we may return them to you.

Graduates of September, 1944 class of St. Joseph Hospital, Paterson, N.J.: This is "Colu"! Please contact me as soon as possible for a reunion. It's been too long since we've seen each other. Mrs. Marie Lenato, 912 Constant Ave., Peekskill, N.Y.

Ella Norhoff, formerly of Boston: Please write to me. I'd like to know your present whereabouts. Lillian M. Joseph, Rt. 1, Box 161, Loma Linda, Calif.

St. Elizabeth Nursing School, Granite City, Ill., alumnae: We're planning a big alumnae reunion on Wednesday, May 12 at the hospital. Please send us your name and address as soon as possible so we can get in touch with you. Mrs. Berneice Gushleff, St. Elizabeth Nursing School, Granite City, Ill.

Grady Hospital School of Nursing, Atlanta, Ga., alumnae: Last year we organized a national alumnae association. Will all graduates please send their name and address to Mrs. Janet Smith, 1301 Eason St., N.W., Atlanta, Ga.

Graduate nurses of Newport Hospital, Newport, R.I.: Please send your address for our records. Our association's 50th anniversary is to be held July 16 through 18 this year. For information—write to Mrs. Anne P. Leys, "Indian Cliffs," 677 Indian Ave., Middletown, R.I.

St. Elizabeth's Hospital, Hutchinson, Kan., alumnae: We're planning a home-coming for all graduates on May 16. Please try to come. Charlotte Ringer, Alumnae Secretary, St. Elizabeth's Hospital, Hutchinson, Kan.

Graduates of the Hudson City-Columbia Memorial School of Nursing, Hudson, N.Y.: The alumnae association wishes to compile a filing system listing all graduates. Please send your maiden name, present name, and address to the alumnae secretary: Mrs. Thomas Carey, 212 Robinson St., Hudson, N.Y.

Latter Day Saints Hospital, Salt Lake City, Utah, alumnae: Please contact Bonnie Wimmer, Corresponding Secretary, Alumnae Association, L.D.S. Hospital, Salt Lake City, Utah. We wish to know your address.

Alumnae of St. John's Hospital, Long Island City, N.Y.: We are revitalizing the alumnae association, would like the names (maiden and married) and addresses of all our graduates. Marie V. Tyrrell, 121 De Kalb Ave., Brooklyn, N.Y.

Is the Polio Vaccine Safe?

Q. Is the vaccine used in the large scale testing program of the National Foundation for Infantile Paralysis being manufactured commercially now?

A. No. The vaccine involved in the validity trials is being made by five manufacturers of pharmaceuticals and biologicals but on a non-profit basis for trial purposes only.

Q. How is the virus grown?

A. The virus is grown in an incubator room in tissue culture flasks containing minced monkey kidney tissues and nutrient fluid—which contains all elements necessary for cell growth. After four to six days in the incubator room, the flasks are removed, and sterility tests are made on the tissue culture. Then 2 cc. of seed virus of one strain of a specific type of virus is added to each bottle. After seeding, the bottles are returned to the incubator room for four more days.

Q. What is happening in the bottles?

A. One or more virus particles attach themselves to one tissue cell and, using the tissue cell as host, each virus particle multiplies. (This is the same process that the virus goes through in the human body in an infection, if sufficient antibodies are not present to stop the process.) Then the flasks are removed and the virus is harvested by siphoning the liquid in the bottle into pooling bottles. The pooling bottles are refrigerated while elaborate safety and sterility tests are carried out on each batch of virus.

Q. What are some of these tests and what do they show?

A. First, as a sterility test, the virus is injected into a battery of test tubes containing a bacteriological culture medium. Any bacteria that might be present would multiply and be discovered through microscopic examination. Second, a safety test is conducted by injecting guinea pigs with the virus. These animals are not susceptible to viruses that cause human polio but are susceptible to any other virus or bacteria that might be in the polio virus. Rabbits are also injected to test for any contaminating agent in the virus.

Q. How is the virus inactivated?

A. The harvested and tested virus arrives at the inactivation stage in flasks, the contents of which are siphoned off into a receptacle. This amount is called a strain pool and each strain pool is handled separately. After formaldehyde is added to each strain pool, the pool is placed in the incubator room and kept at a temperature of 36 to 37° Centigrade for four to ten days. After the maximum period determined by

estimating inactivation time, the strain pool is kept in the room for two more days as an added safety factor. Daily samples are taken for tissue culture tests for the presence of live virus.

Q. *What happens after the inactivated strain pool is removed from the incubator room?*

A. It is refrigerated until the final results of the daily tissue culture tests show that no live virus were left before the pool was removed from the room. Virus from strain pools of each of the three types are then pooled together in equal amounts. (This is the first time they have been combined.) The formaldehyde is now neutralized by addition of sodium bisulphite, and tests are made for sterility and safety of the batch.

Q. *What are these tests?*

A. Sterility is tested by injecting a sample of the vaccine batch into bacteriological culture tubes. Any bacteria present would grow on the medium in the tubes and be readily detected by microscopic examination. Sterility is also tested by injecting at least ten white mice, two or more rabbits and four guinea pigs. This test would reveal the presence of any monkey B virus or meningitis virus.

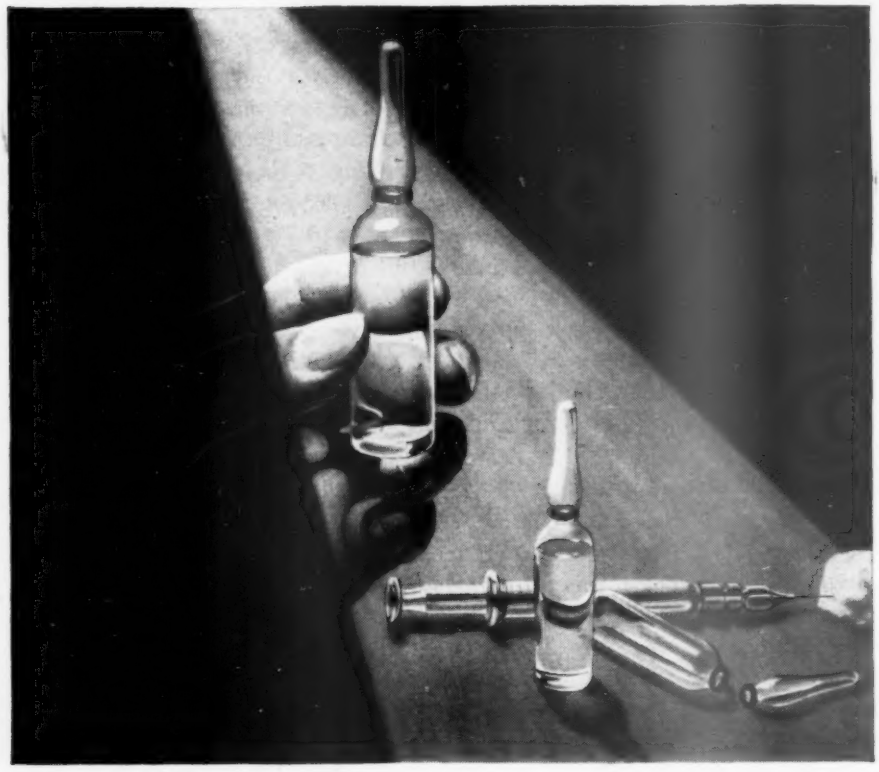
Safety is tested by injecting eighteen monkeys and by making the sensitive tissue culture tests. Twelve monkeys are injected intracerebrally and six intramuscularly and kept under observation for 28 days. At the end of this period, they are autopsied, and tissue samples are taken from their spinal cord and brain stem for microscopic examination for nerve cell damage.

Q. *Does anybody else make tests on each batch of vaccine?*

A. Yes. At the same time the manufacturer is testing each batch, two other laboratories are carrying out identical tests on samples sent them. These are the Virus Research Laboratory of the University of Pittsburgh where Dr. Jonas A. Salk works, and the Laboratory of Biologics Control of the National Institutes of Health, U.S. Public Health Service. Each batch must receive unconditional safety approval from all three before it is released for packaging and shipping to field trial areas.

Q. *Who will receive the vaccine?*

A. In some communities under study all children in the second grade in school will be offered the vaccine. Children in the first and third grades in these communities will serve as the observed control groups. In other communities, where approximately [*Continued on page* 78]



THE BLUE BAND THAT HELPS DOCTORS CONQUER PAIN

You know what a boon to medicine the hermetically sealed ampul has been. It keeps the solution as pure, and as sterile as the day it was packed. Before the Kimble blue band, these ampuls had one big disadvantage, however. They were unhandy to open. Now, with new Kimble Color-Break* Ampuls, opening is safe and easy. Grip! Bend! Snap! And it's ready to use. No filing. No scoring. No sawing.

Many producers of parenteral solutions are already using Kimble Color-Break Ampuls. You can recognize them by the distinctive blue band around the neck of the ampul. When you get a carton of these Color-Break Ampuls remember: Hold the ampul in the regular way . . . press on top as you always have with ampuls. Stem snaps off. You've made a clean, easy break and ampul is ready to use. There is no filing, no scoring, no sawing.

**Color-Break is a trade mark of the Kimble Glass Company, subsidiary of Owens-Illinois*

KIMBLE COLOR-BREAK AMPULS
AN (I) PRODUCT

OWENS-ILLINOIS
GENERAL OFFICES · TOLEDO 1, OHIO

Blood Center

[*Continued from page* 47]

blood ready for shipment. About one hundred donors are handled daily, with 120 as the maximum. Not the least of the chief nurse's worries is to see that the blood is properly refrigerated in the baggage car and that it reaches a Michigan laboratory within forty-eight hours after it is drawn.

The appeal for donors is publicized well in advance of the procurement car's arrival at a given community, through the press, radio, and local Red Cross chapters. Before operating in any locale, approval is obtained from the county (or city) medical societies, health officers, hospital councils, or individual hospitals. Considerable work, including preliminary registration, is done by the local station agents to make sure that everything runs smoothly.

In its travels, the car has called at over sixty communities ranging from St. Paul with 311,349 people to Grace City, N.D.—population 75. Its drawbars have responded to the pull of the road's *Dakotan* as well as branch line locals, mixed trains, and way freights. All races, including Caucasoid, Negroid, and Mongoloid, have participated either as donors or workers on the car. Near Walker, Minn., a bus-load of Indians drove up to the blood center, and typists checked twice before putting down such names as "Thunder" and "Lightening" on the registration card. These first Americans were doubly welcome, for a very large percentage of Indians are said to have Type O blood. Type O, it will be remembered, is also known as the universal donor and has the widest range of safe transfusions.

If the nurses on the blood procurement car work hard—and often overtime—they play hard, too. Unless the unit is in transit on weekends, Saturdays and Sundays are for rest and recreation. In the summer there is swimming, fishing, or picnicking; in winter, ice skating and skiing. All the year round the nurses are invited to dinner by appreciative people along the route and they occasionally participate in folk dancing. The attendant who accompanies the car frequently gets out his guitar, and songfests last until late in the evening.

The favorite pastime, however, is knitting. Next to waiting for the morning mail, the nurses like to knit. But the mail takes precedence over everything! A letter from home, from the boy-friend—well, as one girl put it, "Even a Sears Roebuck catalogue will do in a pinch."

The nurses seldom want for variation and contrast even if the topography is much the same. In Williston, N.D., for instance, Texans with broad-brimmed hats, high-heeled shoes, and undiluted Southern drawls filled the car. They were oil workers brought up from the Lone Star State to exploit the famous Williston Basin in North Dakota and Montana. Frequently DP's from many parts of Europe filed into the car. All in all the "blood center on rails" taps a big chunk of the Central Northwest and a typical cross-section of America.

A physiologically balanced formulation of three well known and widely used compounds:

Neo-Synephrine® HCl, 0.5%
dependable decongestant

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Pharmacophobia

[*Continued from page* 36]

teen more of them to be placed in each of the nurses' stations in the hospital. The representative, as many of them do, expressed surprise that nurses would be interested in the files, but gladly complied with the request. Now other drug companies have been asked for similar card files, and it is hoped that eventually each ward will keep a current listing of proprietary drugs.

So far, most of the methods described as making nurses more familiar with new drugs have followed no specific educational plan. In fact, they have depended chiefly on the doctors' or pharmacists' interest in acquainting the nursing staff with news of the latest drugs.

However, in some of the hospitals, definite educational measures have been taken to orient nurses to advances in treatments and medications. In a city hospital, for instance, which offers an in-service program for staff nurses, six classes on drugs were given in 1952-53, and similar classes are planned for 1954. In another hospital, two one-hour symposiums were held for staff nurses on a new drug, *Alevaire*, which liquefies secretions in various lung conditions. Much of the credit for holding the meetings goes to the chief anesthetist at this hospital who believed that the nursing staff should be fully acquainted with the drug's use, since it was being administered throughout the hospital.

Still another hospital follows a definite routine when an important new drug is introduced on the hospital wards. First, the pharmacist sends literature on the drug to the various floors, then a lecture is given before a hospital assembly. Information is also presented to the students in a class period. Thus, the nursing personnel of the entire hospital is exposed to the latest innovation in pharmacology.

One good method of providing nurses with data on both old and new drugs is a hospital formulary. This handbook, which is generally chained near the medicine cupboard on the wards, lists all of the medications available in the hospital pharmacy. Actually, the formulary represents an attempt on the part of hospital administration to limit the scope of medications available to patients and thus reduce the cost and burden of carrying unnecessary duplicate products and insignificant variations of essential remedies. Secondarily, however, the formulary can be a valuable reference for nurses and doctors, especially if it contains brief descriptions of the drugs and other pertinent information.

Only two of the six hospitals visited had adopted a formulary, and in one of these formularies, only the names of the drugs are listed, with separate sections on weights and measures, metric and apothecary equivalents, and abbreviations. The second formulary would seem to be far more helpful, for it includes "use," "dose," and adds a note of "caution" or "contra-indications" whenever necessary. In addition to

the sections of the formulary mentioned above, it devotes space to pediatric dosage rules, flavoring agents, preparations for diagnostic tests, poisons and antidotes, a therapeutic index, and a general index consisting of both generic and brand names.

Confusion over the multiplicity of brand names now on the market was expressed by some of the pharmacists as well as by the nurses during **R.N.**'s tour of the hospitals. The chief complaints seemed to be: Why are there so many new names? and, Why do so many of the names sound alike?

But if experienced staff nurses sometimes become confused over the number of brand-name preparations used in the hospital, what about nurses who have been inactive for several years? In some cases, directors of nursing in the hospitals reported that inactive nurses have taken refresher courses before returning to work. In all of the hospitals, however, these nurses were said to be supervised closely while giving medications. And one nursing department asks that "rusty" nurses keep a list of the drugs with which they are unfamiliar so that they can be taught more about them.

The inactive nurse who returns to hospital duty may derive some comfort from the fact that the fundamental rules relating to administration of medicines have not changed. Such cautionary measures as reading the label three times and identifying the patient before giving the medication will never be eliminated. On the other hand, in many hospitals, there have been numerous attempts to "streamline" certain procedures involved in administration.

Some of the "streamlining" procedures noted at the six hospitals include: autoclaved syringes in individual paper packets, liquid preparations of atropine and morphine sulfate, portable medicine carts with space for oral and injectable drugs, and cardex systems for listings of patients' treatments and medications. Also, in some of the hospitals, all of the intravenous fluids and transfusions are being given by an I.V. nurse trained by, and working under the supervision of a doctor.

In none of the hospitals are practical nurses allowed to give medica-

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*Portis, Sidney A., Life Situations, Emotions and Hyperinsulinism, J.A.M.A. **142:** 1281-1286 (April 22) 1950.

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tions, although in a ward of one of the hospitals, practical nurse students give insulin under close supervision. It is true, though, that practical nurses do administer drugs in many of the smaller institutions in the state in which this study was conducted. In fact, the administration of medicines is taught during their training period. Nevertheless, it was stressed by a director of an approved practical nurse school in the state that students are told they must follow the practice of the hospital in which they are employed, and that under no circumstances may they administer narcotic drugs.

Undoubtedly, many of the hospitals lose practical nurses because of this restriction on their activities. A director of nursing in one of the hospitals visited stated that a practical nurse employe left her institution because she was not permitted to give medications and treatments. The director happened to see her later and asked how she liked her new job at a smaller hospital in the same city. The practical nurse informed her that she liked it but she was a little worried because several of the aides were encroaching on her duty of administering medications and treatments.

From all accounts—from the Department of Institutions and Agencies, the Board of Nursing, and the six hospitals included on **R.N.**'s observation tour—the problem of narcotic controls seems to be lessening. Although one of the hospitals still does not keep all of its narcotics under double lock as stipulated by the Board of Nursing and the Department of Institutions and Agencies, it is trying to do this in its new wing. Unfortunately, the medicine rooms in the new wing of this hospital have undersized narcotic vaults, so until something else is arranged, narcotics must be locked in one of the cabinet drawers designed for other types of medications.

Narcotic and medicine keys still seem to be a problem, particularly on floors where there are many private duty nurses or where nurses are assigned complete care of a certain number of patients. On a private floor of one hospital which keeps patients' individual medications in five drawers labeled according to room

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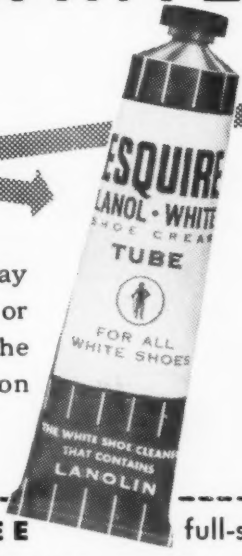

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numbers (e.g., 430-35; 436-40, etc.) it was noticed that all five drawers were unlocked. True, narcotics are not kept in these drawers, but nonetheless, most of the medications given in a hospital can be considered potentially dangerous.

Although there is no law in this state which says specifically that hospitals must account for all hypnotic drugs, all of the hospitals visited keep hypnotics with the narcotics, and require the nurses to count them along with the narcotics either twice or three times in 24 hours. This inclusion of hypnotics with narcotics is a safety measure recommended by the State Board of Pharmacy, and the hospitals appear to have participated wholeheartedly in this voluntary attempt to control what has proved to be a serious problem.

While the inclusion of hypnotics with narcotics is an effective control measure, it can easily be seen that the two categories of drugs often present a problem to nurses who must count each pill and capsule at the end of each shift. Generally, the six hospitals reported that this procedure takes about 15 minutes when the nurse who is coming on duty counts with the nurse who is going off duty.

Several of these institutions, which have fretted over this loss of valuable nursing time, have tried to speed up the counting in various ways. Some pharmacies have reduced the number of pills in the bottle so that they can be counted without removing them from the bottle; others are planning to use larger bottles for the same purpose. A third solution, tried by one hospital, consisted of keeping five narcotic tablets in a transparent capsule. Soon after the adoption of this method to facilitate counting, a capsule containing five tablets of codeine was given to a patient. Although there were no serious effects from this accidental overdosage, the practice was abruptly discontinued. Another institution uses plastic counting trays devised by a pharmaceutical company for counting a number of pills quickly and easily. And a second drug firm, at the suggestion of a nurse at one of the hospitals, includes a measuring sticker with each vial of *Demerol*. When this is fixed to the side of the vial, the amount of fluid remaining can be readily determined. *Demerol*, by the way, has practically superseded morphine sulfate in at least one of the general hospitals included in this informal drug survey.

The facts gathered from this tour of hospitals show that, in general, these hospitals are trying to meet the staff nurses' need for information about new drugs. In only one hospital was there evidence of apathy toward this educational problem. It is true that nurses must take some responsibility for seeking out knowledge by themselves. But it is also true that stimulation to learn is an important factor. And this, as was observed during **R.N.**'s hospital survey, can best be provided by hospitals which realize that the patient's welfare depends, in great part, on the ever-expanding knowledge and skills of their professional nursing personnel.

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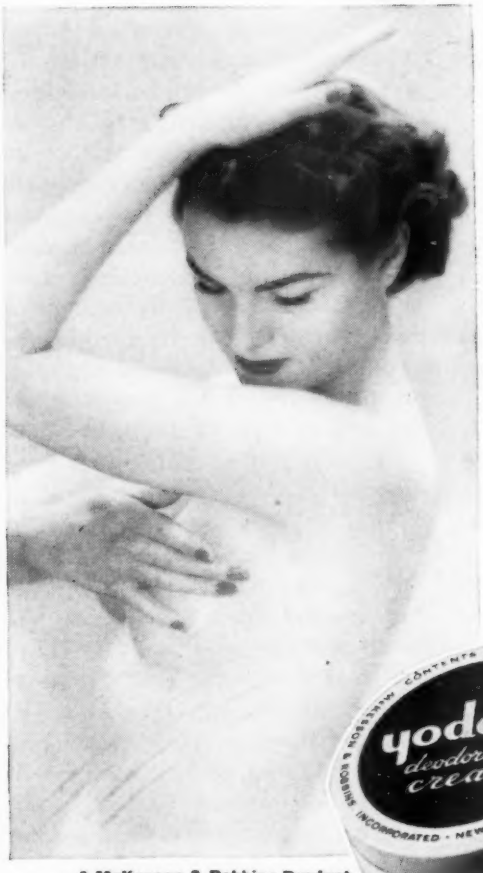

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Candid Comments

[*Continued from page* 39]

of this significant nature were under way in the private duty field, both for the sake of the field and for the lessons its true representatives have to offer. At its best its service is an excellent blend of both the art of healing and the science of nursing. The many intangibles, the tempered judgments, the knowledge of people that make up the art of nursing, come to us through experience—and good private duty nursing has much to share in this area.

But this field is losing its identity as a personalized, skilled service to people who need unusual care. This is due partly to the dilution of the field by temporary workers, or nurses found wanting in other fields, and partly to our disinterest and inattention. It is no credit to the profession that no concerted effort has been made to determine the status of private practice in nursing's changing scene. Is it a career, or merely a stop-gap and emergency service?

For many years this field has either been disparaged and ignored or recognized only in emergency or unusual stress. Yet more nurses are employed here than ever before—70,000—our second largest field. Certainly some major need, over and above that created by lack of hospital personnel, is present to account for this vitality.

The crisis in nursing was decades in the making—it cannot subside in a day. We need to see it in perspective—the long view—rather than in terms of today's frustrations—the short view. Nurses are not generally contemplative by nature, yet our major effort must be to promote thought on the true causes of the crisis, for only when we consider these can we work out the true answers. The *Why* must form a background for the *How*.

Crises of any kind increase our sense of insecurity, but they also make us think. In the end they give birth to new philosophies—the guiding principles and disciplines that govern the objectives and actions of the group. These philosophies can be selfish and destructive or they can be beneficial and constructive.

The philosophy that will emerge for nursing will represent the ideals of the majority. What *do* we want of and for nursing? Are we willing to underwrite its costs in thinking and effort? It takes little of anything to throw a stone at something we don't like. It takes discipline and thought to build that stone into a monument. Our philosophy of life actually is the expression of our faith—the things we believe in. Our faith falters when we judge only in terms of the scene immediately before us. The short view is good only for today. The long view is not a matter of years but of minds and attitudes, of disciplines in studying, and thinking, and weighing. For us it is a matter of regarding nursing not solely as a means to our personal ends, but as a great and beneficent service that must ever mold its purposes and practices to the needs of mankind.

Retrolental Fibroplasia

[*Continued from page* 45]

is the possibility of the disease developing in the premature.

The treatment of the developing lesions is actually a matter of doing the best that is possible. Nothing has been found that can be considered a specific cure or even be considered beneficial in every case, and almost everything from oxygen and cortisone to irradiation has been tried. Currently, oxygen therapy is receiving the most serious consideration. If the disease develops while oxygen is being administered because of prematurity, the usual procedure is to raise the oxygen concentration in order to reverse the disease process. The infant is then weaned from oxygen through a gradual reduction in concentration until atmospheric conditions are reached.

Cases that are not receiving oxygen and in whom the disease develops are treated by the administration of 50 per cent oxygen. If the disease continues to progress, the oxygen concentration is raised to about 65 per cent, and at the point of optimum improvement it is again reduced gradually to atmospheric concentration. Weaning to atmospheri concentration can be interrupted an reversed at any time, whenever the need arises. Usually the weaning is extended over a five to six weeks' period. If no improvement results from this treatment, it is not likely that any is possible with any other known therapy. Cortisone, alone or in addition to oxygen, is thought to be beneficial in some cases, however.

Because of the occurrence of this disease among prematures, and because there is so little knowledge regarding it, parents and friends of parents of premature infants may often become panicky at its mere mention. Rumor thrives and gives rise to stories which either paint the picture even blacker or which raise false hopes because they describe "magic" treatments which are ineffective in practice. At present, retrolental fibroplasia is the subject of intensive research. Nurses are in a position to be of service because they can help distracted parents differentiate between fact and fancy in relation to this condition.

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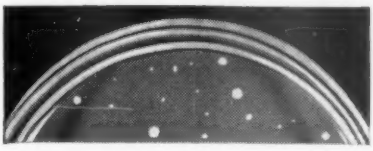

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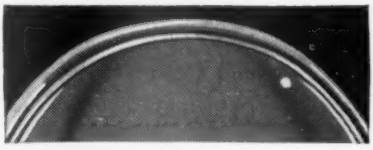

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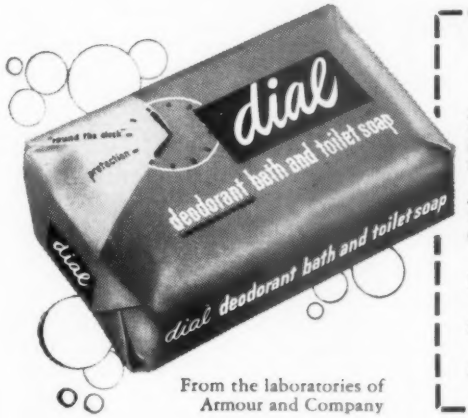

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Animal Parasites

[*Continued from page* 49]

and is careful not to reinfect himself by wearing contaminated clothing or sleeping in contaminated bed clothes.

Pediculosis has a more genteel connotation than "lousiness," but the fact remains that both are one and the same. Before the advent of DDT in World War II, the body louse, especially in wartime, was not only disgusting but dangerous for it transmitted the diseases of typhus, relapsing fever, and trench fever. With the introduction of the miracle insecticide, however, the incidence of these diseases has been markedly reduced.

This does not mean that the body louse has become extinct. It may still be found in persons who do not bathe frequently, particularly among old men and vagrants. The favorite sites of these pediculi are the seams of underwear—there the pediculi can be found near groups of small, pearly yellow nits. From this vantage point, they can attack the skin whenever they require nourishment. Due to the intense itching, there will often be scratch marks on the skin where the clothing seams come in contact with it.

In the treatment of the ordinary case of pediculosis corporis, the patient is instructed to bathe in warm water, soap himself for 10 or 15 minutes, and rinse his body thoroughly in clear water. All of his contaminated clothing should be washed and boiled, or discarded. Large groups of verminous people were successfully deloused in the last war by spraying their clothing and bodies with DDT compounds.

Unlike pediculosis corporis where the lice are able to survive in clothing, the two other species of lice—Pediculus capitis and Phthirius pubis—cling to the hairs. The lice with which nurses or, at least, school nurses are most familiar are the organisms responsible for pediculosis capitis.

The head louse measures about 2 mm. in length and is of a grayish or brownish color with black spots. Since pediculosis lesions first appear and predominate in the occipital region, one should always suspect the presence of lice when there is an itching or impetigo at this site. The gray pear-shaped eggs or nits of the louse are laid on the hair after the louse punctures the scalp to suck blood. These eggs, which can be differentiated from dandruff and scales because of their geometric and glistening appearance, can be moved up and down the hair shaft, a characteristic that has led one dermatologist to liken them to tight rings on a curtain rod. If pediculosis capitis remains untreated, the primary lesions may be complicated by impetigo and other severe infections.

The treatment of pediculosis capitis has advanced considerably in recent years, offering a marked contrast to prolonged therapy with such agents as kerosene and petrolatum. The newer drugs take less time to apply and are more effective in a shorter period of time. The pediculicides discussed in *Drug Digest*,

page 50, are those included in *New and Nonofficial Remedies*, the publication that lists the drugs accepted by the AMA Council on Pharmacy and Chemistry. But there are also many other satisfactory agents on the market.

The third form of pediculosis, pediculosis pubis, is caused by Phthirius pubis or crab louse. Although this louse generally infests the hairs of the genital region, it may be found also in the hairs of the eyebrows, eyelashes, beard, axillas, and on the bodies of particularly hairy persons. The disease is transmitted through sexual intercourse, bedclothing, and toilet seats.

In treating cases of pediculosis pubis, it may be necessary to shave the hair in the affected areas. If secondary dermatitis is present, it should be appropriately treated before parasiticidal remedies, such as DDT, are applied. Otherwise these agents may aggravate the secondary dermatitis. If the eyelids and eyelashes are infested, the parasites should be carefully removed with forceps and 2 per cent yellow mercuric oxide ointment rubbed into the hairy parts.

Pediculosis and scabies are two diseases that will probably continue to plague the "unwashed." Therefore, until the rules of hygiene become more widely adopted, we cannot hope for their demise. In the interim, however, it is encouraging that these animal parasites can be readily eradicated through the use of insecticides and specific pharmacological agents.

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News in Review

[*Continued from page* 54]

the state of Minnesota receive $13 for each eight-hour shift . . . Fees for private duty nurses in New Jersey have been raised to $14 for an eight-hour shift. New Jersey private duty nurses have requested that the hospitals bill them directly for their meals instead of their patients . . . In Washington, D.C., the Graduate Nurses Association has authorized a raise in private duty rates from $12.75 plus one meal to $15 per eight-hour day. Nurses receiving the higher fee will pay for all their meals.

▶ NEWSLINGS: Crying "unfair competition," the American Association of Nursing Homes has gone on record against proposed federal grants for the building of nonprofit nursing homes. Robert F. Muse, executive director of the Massachusetts chapter of the AANH, argued before the House Commerce Committee that proprietary nursing homes would be at a very definite disadvantage if they had to compete with institutions receiving government grants of aid . . . The Canadian Nurses Association has applied to the Parliament of Canada for an amendment to its Act of Incorporation which would make it possible to admit the Association of Registered Nurses of Newfoundland to its membership . . . Among those organizations, listed in the *Congressional Record*, whose lobbying expenditures during the first nine months of 1953 ran to four figures was the ANA.

Polio Vaccine

[*Continued from page* 57]

twice as many children will be involved in the trials, children in the first three grades in school will be inoculated. However, only half of them will get the vaccine; the other half will receive a similarly packaged ineffective fluid which cannot be differentiated from the vaccine (control solution). Only the evaluation team will know which children received which fluid.

Q. Who will administer the program in trial areas? How will vaccine be given?

A. Local health authorities in cooperation with the NFIP. Local doctors and nurses will volunteer their assistance through their local professional organizations. There will be three injections of 1 cc. each, given in the arm. The second shot will be given one week later; the third shot at least four weeks after the second.

Q. When will the trial vaccine be given?

A. While the trials started at the end of March, later than the anticipated date, every effort will be made to finish the trial vaccinations before the polio epidemic season starts. In case of signs of an early epidemic in a selected area, the decision whether to continue or to stop the trials would be made by the State Health Officer on the basis of available data.

Q. How will the results of the trials be evaluated?

A. Dr. Thomas Francis, Jr., Chairman of the Department of Epidemiology in the University of Michigan School of Public Health and one of the nation's leading authorities on epidemics, has agreed to direct the evaluation. He will select a team of scientists to make an independent study of the effectiveness of the trial vaccine by comparing the incidence among vaccinated groups and control groups. The results will not be available until some time in 1955.

Q. Is this trial vaccine regarded as the final answer to paralytic polio?

A. No. Research on improved vaccine is continuing in Dr. Salk's laboratory and in laboratories throughout the country. This trial vaccine represents the first step, through mass trials, to evaluate the effectiveness of polio vaccine.

Q. Is the trial vaccine's safety being tested also?

A. Absolutely not. The vaccine has proved to be safe.

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ANESTHETIST: Starting salary $350 mo. Methodist Hospital, 6th St. and 7th Ave., Brooklyn, N.Y. SO8-6000, Ext. 142.

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ANESTHETISTS: (a) Group 4 med. anes. Priv. & hosp. anesthesia, Ob wk only. Ofc in 500 hosp, Calif. (b) Gen'l hosp. 500 beds $6000, 2 days off during week for one call every 5th week-end. 3 calls per mo. Twn 50,000 1 hr. to NYC. (c) Gen'l hosp. 165 beds, about $6000, Ind. (d) Gen'l hosp. 130 beds. $7200. Excel. winter, summer resort, Mich. (e) Vol. gen'l hosp. 25 beds. About $7200, lge. city, MW. (f) Chief, vol. gen'l hosp. 120 beds heavier types of surg. About $6000, S.E. (g) AANA, gen'l hosp. 45 beds. $6000 plus full mtce. S. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

ANESTHETISTS: (a) Two. 350 bed hosp. med. anes. in charge. Univ. city near NYC. (b) Gen'l 125 bed hosp. coll. town, Pac. NW. Free lance or sal. (c) Lge. gen'l hosp. Pac. Islands. (d) Clinic, 7 Board men, resort town. Fla. Min. $500. (e) New 235 bed hosp. $500-$600, MW. RN4-2 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ASSISTANT TO DIRECTOR OF NURSING SERVICE: 225 bed general hospital, all-graduate nurse staff. Write to Director of Nurses, St. Francis Hospital, Miami Beach, Fla.

CLINIC: (a) Well-equip'd cl. Small hosp. Excel. med. staff, Calif. (b) Chief. out-patient, new dept. Vol. gen'l hosp. 320 beds. Outstanding facilities. Lge. city, Central. (c) Health resort, no surg'l. Bedside nurs'g. Resort center, MW. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

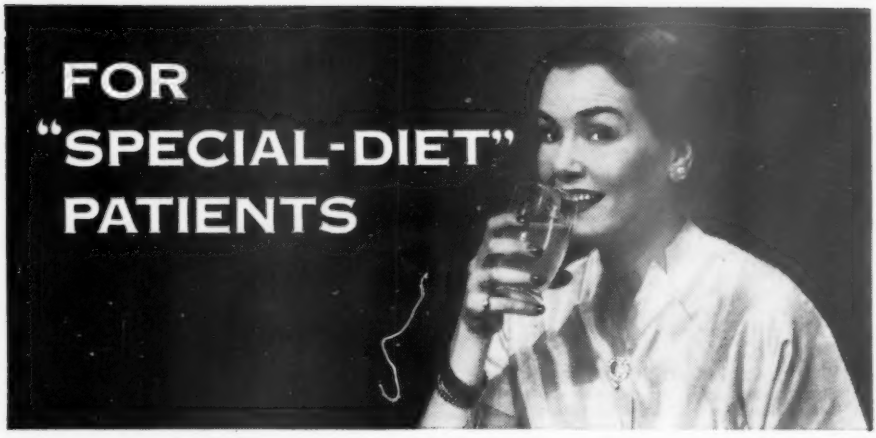
CLINIC, INDUSTRIAL, OFFICE: (a) Chief nurse, indust. clinic. Chgo. (b) Courier nurses, transcontinental. (c) Insurance. Some travel. MW. (d) Neurological nurse, office, neurosurgeon, univ. city, MW. (e) College, co-ed. Sept. '54. RN4-3 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

CLINICAL INSTRUCTOR: (Medical-Surgical Ward). 260 bed general hospital. School nationally accredited. Degree required, experience desirable. 40 hr. week, good personnel policies. Salary commensurate with preparation and qualification of applicant. Apply Director, School of Nursing, Evangelical Deaconess Hospital, St. Louis 10, Mo.

CLINICAL INSTRUCTOR-MED. & SURG.: 40 hr. week. Salary commensurate with experience and preparation. Liberal personnel policy. Approved school of nursing 30 minutes from New York City. Apply Director of Nurses, Clara Maass Memorial Hospital, 16-12th Ave., Newark 3, N.J.

DIETITIANS: Opening for two recent graduate Therapeutic A.D.A. Dietitians. 40 hr. week, free Blue Cross, libel salary and life insurance, 3 weeks paid vacation. Apply Trumbull Memorial Hospital, Warren, Ohio.

[Turn the page]



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DIRECTORS OF NURSES: (a) Gen'l 300 bed hosp. 100 students. Coastal city, E. $6000, mtce. (b) Gen'l 275 beds. Coll. town MW. $7200. (c) Psy. hosp. outside US. (d) Nurs. service, ortho hosp. 90 beds, fine set-up. Univ. city. (e) New hosp., small, med. cases only. Calif. (f) Beautiful new TB hosp. Univ. town, MW. $6500, mtce RN4-4 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

EDUCATIONAL DIRECTOR: School nationally accredited. Degree required, experience desirable. 40 hr. week. Good personnel policies. Salary commensurate with preparation and qualification. Apply Director School of Nursing, Evangelical Deaconess Hospital, St. Louis 10, Mo.

FACULTY POSITIONS: Including Nursing Arts Instructor, Medical and Pediatric Clinical Instructors, Evening Supervisor and Head Nurses. Inquire: Director of Nursing, The Lutheran Hospital, Fort Wayne, Ind.

FACULTY POSTS: (a) Ed. dir. Collegiate sch. Vol. gen'l hosp. 100 beds, req's M.S. & exper. About $5500. Lovely col. twn 100,000, MW. (b) Ed. dir. 2 yr. prog. Collegiate sch., pref. MS. Consid. R.N. with B.S. S. (c) Ass't Dean, 150 students, univ. school. (d) Ed. dir. 100 students, coll. affiliated for basic, sc. Attrac. twn 50,000, Pac. NW. (e) Nurs. arts instr. pref. with sc. degree. Excel. sch. college affil'd. Gen'l hosp. 90 beds. About $5000. Iowa. (f) Nurs. arts. inst. Full faculty rank. 70 students. Collegiate sch. $5000. Coll. twn. Mich. (g) Clinical inst. med. & surg. nurs'g. Also req. ass't, 90 students. Univ. aff'd. Univ. med. center, MW. (h) Clinical inst., pediatrics. One qual. to develop into Ass't dir. carrying some adm. work, outstand'g children's hosp., 125 beds, S. (i) Sc. inst. One class. 60 students, NLN acc'd vol. gen'l hosp. Boston area. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

FACULTY POSTS: (a) Educ. dir. Univ. hosp., Asia. (b) Ed. dir. univ. hosp. med center, So. Min. $400, mtce. (c) Ed. dir. Univ. school, 200 students. $6000, MW. (d) Nursing arts & clin. ortho. & ob. New hosp. 300 beds, Pac. Coast. (e) Science. (f) Clinical in TB., affil. school. NW. $4400, mtce. (g) Clinical, med. & surg., small school, med center. $5000. RN4-5 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

GENERAL DUTY NURSES: 25 bed hospital. Needed on or before May 1st. $175 starting salary and full maintenance. For particulars write Nina W. Cranney, Supt., Lincoln County Miners Hospital, Kemmerer, Wyo.

GENERAL DUTY NURSES: All departments, 200 bed hospital. Salary $11-$12.60 per day plus P.M. and night bonus. Sick and vacation allowances. Quarters available adjoining hospital $18 per mo. Send full details and snapshot to: Director of Nurses, Doctors Hospital, 12345 Cedar Road, Cleveland Heights, Ohio.

GENERAL DUTY NURSES: For beautiful crippled children's hospital loated in heart of historic west. Salary starts at $205 per mo. with complete maintenance, 15 days vacation, 15 days sick leave, 5 day work week. Climate is warm and dry. Hospital has indoor and outdoor pools available to personnel. Contact director of nurses, Carrie Tingley Hospital for Crippled Children, Truth-or-Consequences, N.M.

GENERAL DUTY NURSES: For medical, surgical and maternity services. New 200 bed hospital, good personnel policies, 44 hr. week, including 7 holidays, hospitalization, Social Security. Apply Director of Nursing, Chambersburg Hospital, Chambersburg, Pa.

GENERAL DUTY NURSES: For 120 bed hospital. Starting salary $237.50 with a charge of $22.50 for full maintenance. 40 hr. wk. Surgical Nurses, starting salary $247.50. Additional $10 per mo. for evening and night duty, regular increases. Nurses' home recently redecorated and refurnished. Liberal personnel policies. Hospital approved A.C.S. Southern Wyoming community of 12,000. Write or wire Director of Nurses, Memorial Hospital, Rock Springs, Wyo.

GENERAL DUTY STAFF NURSES: For 165 bed hospital in residential suburb of Chicago. 40 hr. duty after 9/1/53. Cash salary $215 for day duty, $225 for evening duty and $230 for night duty. Full maintenance in addition to salary includes single room in new nurses' residence plus meals and laundry, which is equivalent to $335 per mo. Low rental apartments for married nurses, and $25 additional salary rate for nurses living in their own homes. $10 increase after 60 days and at regular intervals. Two to four weeks vacation, 6 holidays, sick time policy, free life insurance, Blue Cross hospitalization available. Leave of absence with full salary for post-graduate experience. Write Director of Nursing, MacNeal Memorial Hospital, Berwyn, Ill.

GENERAL STAFF NURSES: This is a nice place to work in preferred department of 200 bed general hospital with liberal personnel policies including 40 hr. wk., choice of two schedules, retirement plan, paid hospitalization insurance premium, cumulative 30 day sick leave, pro-rated and progressive vacation, 6 holidays annually, meals at cost,

rooms for $20 monthly in residence beautifully located directly on Detroit River and 30 minutes from Detroit. Beginning salary, evenings $304.47-$313.13; nights, $299.47-$308.13; days, $289.47-$298.13. For details write Director of Nursing, Wyandotte General Hospital, Wyandotte, Mich.

GENERAL STAFF NURSES: 250 bed general hospital and 72 bed maternity hospital. Starting salary $280, $5 per month tenure increase for each 6 months of service to a maximum of $310. Social Security, sick leave, prepaid medical and hospital care. $10 additional for afternoon and night shift, $10 additional for delivery room, $20 additional for surgery. Up to 3 weeks vacation at end of 4 years. 7 paid holidays, 8 hr. day, 40 hr. week. Apply to Director of Nurses, Sutter Hospital, Sacramento, Calif.

GRADUATE NURSES: For 240 bed hospital for tuberculosis adults and children. Salary $245 to $305 per mo. plus full maintenance. 44 hr. week, vacation, 10 holidays and sick leave with pay. Retirement plan in effect. Ideal climate, few apartments available for married nurses with family. Apply to James J. Barfield, M.D., Medical Supt., Fort Stanton Medical Center, Fort Stanton, N.M.

GRADUATE NURSES: Contact Director of Nursing Service, William Newton Memorial Hospital, Winfield, Kans.

GRADUATE NURSES: Public Health Training Program open to graduate nurses 20 to 40 years, $3889 to $3971 per year. Trainees take academic work at University while gaining paid experience in field. Other openings for trained public health nurses, 22 to 45 years, $2971 to $4350 per year. 40 hr. week, liberal paid vacations, sick leaves, pension system, Civil Service status, educational leaves. Apply Detroit Civil Service Commission, 735 Randolph St., Detroit 26, Mich.

GRADUATE REGISTERED NURSES: For general duty, 3-11 and 11-7. Small 40 bed general hospital. Salary open. With or without maintenance. Write Superintendent, Jersey Shore Hospital, Jersey Shore, Pa.

GRADUATE REGISTERED NURSES: For 398 bed General Hospital with School of Nursing. Full or part-time. Excellent opportunity for study at Western Reserve University. Starting salary $240-$260 based on experience plus $1.00 per diem for evening or night duty. Operating room nurses $10 per mo. additional. Two weeks vacation, 6 holidays, 10 days sick leave. For detailed personnel policies write Director of Nursing, Mount Sinai Hospital of Cleveland, 1800 East 105th St., Cleveland 6, Ohio.

GRADUATE STAFF NURSES: For 57 bed convalescent home (branch of Presbyterian Hospital). Adults & children. 40 hr. wk. 80 acre estate. Start at $250 monthly. Maintenance. Many employee benefits. Write Miriam Hubbard, R.N., Supt., King St., Port Chester, N.Y.

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access all N.Y.C. universities. Staff nurse salary $260-$300, evening bonus $50 monthly, night $40. 5 uniforms laundered weekly, paid Blue Cross, Social Security, 4 weeks vacation and other benefits. Minimum rotation. Housing agent helps you locate. Write Director of Nursing, Memorial Center, 444 East 68th St., New York 21, N.Y.

INFANT NURSES: For Pediatrics, Nursery and Formula Room. Liberal personnel policies, differential for evening and night duty. Salary $195 month. New, extremely modern 144 bed hospital. Apply Personnel Director, St. Luke's Hospital, Saginaw, Mich.

INSTRUCTOR & SUPERVISOR OF AUXILIARY PERSONNEL: 106 bed general hospital. Position open, salary open. Liberal personnel policies. Apply to Director of Nursing, Middlesex General Hospital, New Brunswick, N.J.

MALE NURSES: (a) Supt. private psy. hosp. Univ. city, MW. $5200, mtce. (b) Anes. Ass'n anes. group. Pac. Coast. RN4-6 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

MALE REGISTERED NURSES: Attractive openings in new, extremely modern 144 bed hospital for Medical Service and Operating Room. Excellent salaries and personnel policies. No living-in accommodations, living facilities available near hospital. Apply Personnel Director, St. Luke's Hospital, Saginaw, Mich.

NURSE ANESTHETIST: 250 bed hospital, well equipped and fully approved. Predominately surgery, top salary, meals and laundry furnished, good hours, sick leave, vacation and holidays. Apply Administrator, Mid-State Baptist Hospital, Nashville, Tenn.

NURSE ANESTHETIST: Approved hospital, convenient transportation. Salary open. Apply Administrator, Hospital of St. Anthony de Padua, 2875 West 19th St., Chicago, Ill.

NURSE ANESTHETISTS: Two, to increase staff. Working conditions excellent. Apply Chief, Anesthesia Dept., Mercer Hospital, Trenton, N.J.

NURSE-ANESTHETISTS: 175 bed hospital, predominantly surgery, living quarters available, salary open. Department headed by physician-anesthetist. Apply Mass. Eye & Ear Infirmary, 243 Charles Street, Boston 14, Mass.

NURSE, REGISTERED: 40 hr. week, starting salary $240 for days, other shifts $250 plus meals, apartments available, non-sectarian hospital. Write Director of Nurses, St. Francis Hospital, Cambridge, Ohio.

NURSES: Registered, graduate or practical nurses. Night or day. Deborah Sanatorium, Browns Mills, N.J.

NURSES: Operating Room and General Staff duty for 225 bed well-equipped hospital. 40 hr. wk., Social Security, sick leave, vacation. Apply to Director of Nurses, St. Francis Hospital, Miami Beach, Fla.

NURSES: Positions available for R.N.'s under age 50. Beginning salary $300 per mo.

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NURSES: General hospital, 236 beds, new building, modern equipment. 30 miles from New York City. Liberal personnel policies. Write Director of Nursing, Morristown Memorial Hospital, Morristown, N.J.

NURSES: General Duty Nurses wanted for summer positions commencing June 1 through October 31. Spend your summer in Bar Harbor, gateway to beautiful Acadia National Park. Write for full details, Mount Desert Island Hospital, Bar Harbor, Me.

NURSES: Registered, for positions in modern 115 bed community hospital in Greater Washington (D.C.) area. 40 hr. week, bonus for evening and night duty. Maintenance if desired. Apply Director of Nurses, Suburban Hospital, Bethesda, Md.

NURSES: How would you like to practice nursing from June 19th thru' Aug. 21st among the aspen and pine trees at a mountain Girl Scout Camp? Requirements: R.N., First Aid training, 21-35 years. Salary $175. Write Mrs. D. E. Mayhugh, 329 Davis, Pueblo, Colo.

NURSES: General Duty, for 30 bed hospital 35 miles from New York. Excellent salary. Apply Administrator, Tuxedo Memorial Hospital, Tuxedo Park, N.Y.

NURSING ARTS INSTRUCTOR & ASS'T TO MED-SURG. INSTRUCTOR: 300 bed hospital 30 mi from Pittsburgh. Opportunity to attend university. School of nursing, 100 students. Qualifications for Nursing Arts Instructor: B.S. in Nursing Education, major in Nursing Arts, experience as head nurse. For Assistant Clinical Instructor: Experience as head nurse, university preparation for teaching, some advanced work in Medical and Surgical Nursing. $325 a mo. Responsibilities entirely teaching. Maintenance available if desired. Apply Box BSMH-1 c/o R.N. Magazine, Rutherford, N.J.

OBSTETRIC CLINICAL INSTRUCTOR-ASST. SUPERVISOR: Small dept. in 106 bed general hospital. Position open, salary open. Liberal personnel policies. Apply to Director of Nursing, Middlesex General Hospital, New Brunswick, N.J.

OBSTETRICAL SUPERVISOR: 225 bed general hospital. Accredited school 75 students. Degree required or special preparation for teaching obstetrics. 40 hr. week and employee benefits. Apply Director of Nursing, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

OPERATING ROOM: Scrubnurses positions available. Information regarding policies may be obtained from Sr. Raymond Mary, R.N., O.R. Supervisor, St. Anthony's Hospital St. Petersburg, Fla.

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$210 per mo. and full maintenance, additional for first and second call. For further details apply to: Operating Room Supervisor, Southwestern General Hospital, El Paso, Tex.

OPERATING ROOM NURSES: For 200 bed hospital. New and modern surgery. Good working conditions with 44 hr. week. Apply Director of Nurses, Chambersburg Hospital, Chambersburg, Pa.

OPERATING ROOM SUPERVISOR: B. S. Degree and/or satisfactory experience. Duties include administration and supervision of teaching program. Clinical instructor employed for teaching purposes. Over 7,000 operations yearly. Salary excellent. Liberal personnel policies include: 40 hr. week, 8 legal holidays, 12 days sick leave, 30 days vacation. Social Security. Comfortable living quarters and meals available at low cost. 30 minutes to center of New York City. Apply Director of Nursing, Newark Beth Israel Hospital, 201 Lyons Ave., Newark 8, N.J.

OPERATING ROOM SUPERVISOR: 250 bed hospital. Nationally accredited school of nursing. Administrative and teaching responsibilities, college credits, degree preferred. 40 hr. week. Good personnel policies. Salary open, annual increments. Mature, experienced person desired. Apply Director of Nurses, Deaconess Hospital, St. Louis, Mo.

OPPORTUNITIES FOR GENERAL DUTY NURSES: For 7-3 or 3-11 shifts. 5 day, 40 hr. week. Meals, laundry, generous prequisities. New salary schedules with regular advancement. Write or call Director of Nursing, John C. Proctor Hospital, Peoria, Ill. Phone 4-4121.

PEDIATRIC SUPERVISOR: Well prepared by education and experience to assume dynamic leadership in a pediatric-orthopedic division that is going to grow from 25 beds to 55 beds in a thoroughly modern department within the next 18 months. Must be sympathetic toward and willing to take a very active part in the educational program of the School of Practical Nursing. General personnel policies are good and the salary offered will be commensurate with the qualifications of the person chosen to fill the position. Apply Director of Nursing, Hospital for Joint Diseases, 1919 Madison Ave., New York 35, N.Y.

PROFESSIONAL REGISTERED NURSES: Supervising Nurse, $306.50 per mo., Professional Nurses, $291 per mo. Full maintenance, private room, new nurses' residence. 40 hr. week, sick leave, annual vacations, legal holidays. Operating room and staff positions open in 600 bed Tuberculosis Hospital. Excellent opportunity for experience in thoracic surgery. Staff positions in 2250 bed geriatric hospital. Hospitals located 22 miles from Chicago. Write or contact Administrator of Nurses, Oak Forest Institution, Oak Forest, Ill.

PSYCHIATRIC CHARGE NURSE: Mature R.N. or practical for day or night duty in 70 bed private psychiatric hospital. Complete maintenance. Experience not necessary. Baltimore suburbs. Dr. Taylor, Taylor Manor, Ellicott City, Md. [Turn the page]

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Choice fruits and vegetables picked at peak of ripeness are *finer flavored*. When food *tastes* good, Baby thrives *emotionally* as well as physically.

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PUBLIC HEALTH NURSES: (2) Wanted immediately for a generalized public health nursing program in an official agency in a city of 22,000 surrounded by prosperous agricultural area, a college town 50 miles from Denver, Cheyenne and Estes Park, the Gateway to the Rocky Mountain National Park. 40 hr. working week. Salary commensurate with education and experience. Write to Weld County Health Department, P.O. Box 521, Greeley, Colo.

REGISTERED NURSES: All shifts. 280 bed general hospital with emphasis on Orthopedics. General personnel policies are good and salaries are commensurate with education and experience. The hospital is located near all transportation for easy access to colleges, universities and New York City's other cultural advantages. Some living-in accommodations are available at reasonable cost. Applicants must be sympathetic toward and willing to participate in the practical nurse training program of the hospital. Apply Director of Nursing, Hospital for Joint Diseases, 1919 Madison Ave., New York 35, N.Y.

REGISTERED NURSES: For new modern 144 bed hospital. Staff and supervisory positions open in all services for all shifts, evening and night differential. Beginning salary $260. Excellent personnel policies, no living-in accommodations, living accommodations available near hospital. Apply Personnel Director, St. Luke's Hospital, Saginaw, Mich.

REGISTERED NURSES: P.G. courses or years of experience in Obstetrics. Good personnel policies. Nurses experienced in Operating Room and Out Patient. Same requirements. 200 bed general hospital. Address reply to Box 840, Battle Creek, Mich.

REGISTERED NURSES: Capable of giving anesthesia. Liberal personnel policies, good salary. Write Laura G. Yamamoto, Adm. Molokai Community Hospital, Hoolehua, Molokai, Hawaii.

REGISTERED NURSES: One or two, small hospital in fast-growing community in scenic area of Eastern Utah. Write or apply to Administrator, Grand County Hospital, Moab, Utah.

REGISTERED NURSES: For a 48 bed general hospital. Basic salary of $260 per mo. for a 5 day 40 hr. week with increases at 6-12-24-36 and 48 mo. intervals. $20 extra

Fresh-Frozen and Freshly-Squeezed Orange Juice

Two years ago, findings of importance to dietitians everywhere were published, emphasizing the superiority of reconstituted MINUTE MAID Fresh-Frozen Orange Juice over home-squeezed juice of the same type oranges, in three respects:

(a) *Average levels of ascorbic acid significantly higher:* Obviously, this advantage of MINUTE MAID, observed in samples tested, is susceptible to variation, from season to season, as crops differ. It should be emphasized, however, that, penny for penny and year after year, the lower-priced MINUTE MAID offers *more* ascorbic acid than home-squeezed orange juice.

(b) *Peel oil content significantly lower:* Samples of orange juice, home-squeezed by typical housewives, showed that contents of peel oil, a cause of allergic response and poor tolerance, especially in infants, were up to 700% higher than in MINUTE MAID!

(c) *Bacterial counts dramatically lower:* Bacterial counts were found to be as high as 350,000 per ml. in home-squeezed juice, but were uniformly low in MINUTE MAID.

Since publication of the above, more and more physicians are recommending MINUTE MAID in place of home-squeezed orange juice. And now comes more evidence in favor of MINUTE MAID . . .

New Assays Reaffirm Dietary Advantages of Minute Maid Fresh-Frozen Orange Juice on a Cost Basis

A second report comparing the individual mineral and vitamin values of MINUTE MAID Fresh-Frozen Orange Juice and home-squeezed juice of the same type oranges has recently been published. In this latest study, each sample was analyzed separately:

TABLE: *Mean Values in Samples Tested*

COMPONENT	UNITS	MINUTE MAID FRESH-FROZEN ORANGE JUICE	HOME-SQUEEZED ORANGE JUICE
Betaine	mg./100 ml.	49	46
Biotin	mcg./100 ml.	0.26	0.26
Choline	mg./100 ml.	12	12
Cobalt	mcg./100 ml.	74	67
Folic acid	mcg./100 ml.	2.2	2.2
Iodine	mcg./100 ml.	0.24	0.21
Manganese	mcg./100 ml.	33	18
Nitrogen			
Total	mg./100 ml.	104	79
Amino	mg./100 ml.	22	22
Volatile	mg./100 ml.	8	7
Non-volatile	mg./100 ml.	96	72
Pantothenic acid	mcg./100 ml.	146	145
Para-amino-benzoic acid	mcg./100 ml.	4	4
Phosphorus	mg./100 ml.	19	18
Potassium	mg./100 ml.	380	290
Riboflavin	mcg./100 ml.	18	17
Tocopherols	mg./100 ml.	107	104
Vitamin A	mcg./100 ml.	19	16
Thiamine	mcg./100 ml.	87	83
Vitamin B_{12}	mcg./100 ml.	0.0022	0.0012

Although the results are again susceptible to variation according to crop and year, Fresh-Frozen MINUTE MAID was equal to the home-squeezed juice in the samples tested for the largest number of components listed; and in the mean values for iodine, manganese, potassium, Vitamin A and Vitamin B_{12}, MINUTE MAID showed appreciably *higher* values.

SUMMARY

These new findings help enlarge professional knowledge of the nutrient constituents of orange juice in general and add fresh evidence that, on a cost basis, MINUTE MAID Fresh-Frozen Orange Juice offers not only *more* Vitamin C, but also *more* of all the other vitamins and minerals listed.

Taken in conjunction with the previously published findings, this should confirm the choice of physicians who recommend MINUTE MAID in place of home-squeezed orange juice.

REFERENCES:

(1) Rakieten, M. L., *et al.*, Journal of the American Dietetic Association, October, 1951.

(2) Joslin, C. L., and Bradley, J. E., Journal of Pediatrics, Vol. 39, No. 3, pp. 325-329 (1951).

(3) Rakieten, M. L., *et al.*, Journal of the American Dietetic Association, November, 1952.

(4) Assn. Off. Agric. Chemists: Methods of Analysis, 7th ed. Wash.: Assn. Off. Agric. Chemists, 1950.

Reference #3 still available in reprint form.

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Wallace R. Roy, Ph.D., Director of Research

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[Turn the page]

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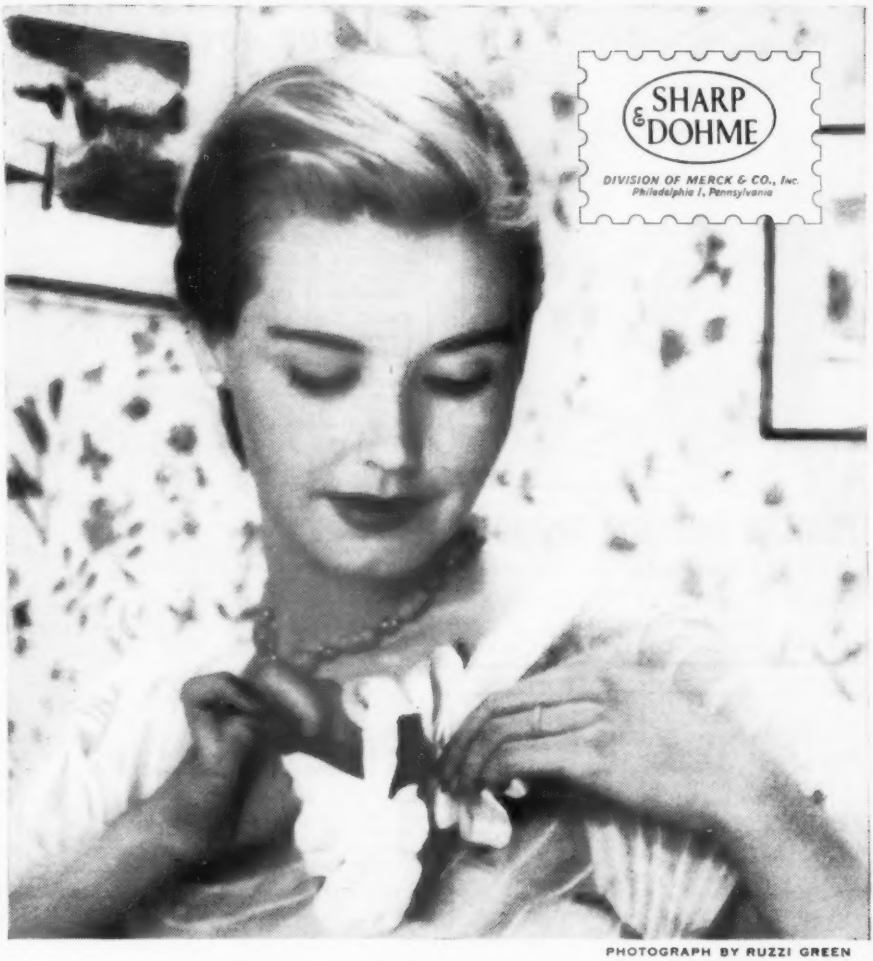

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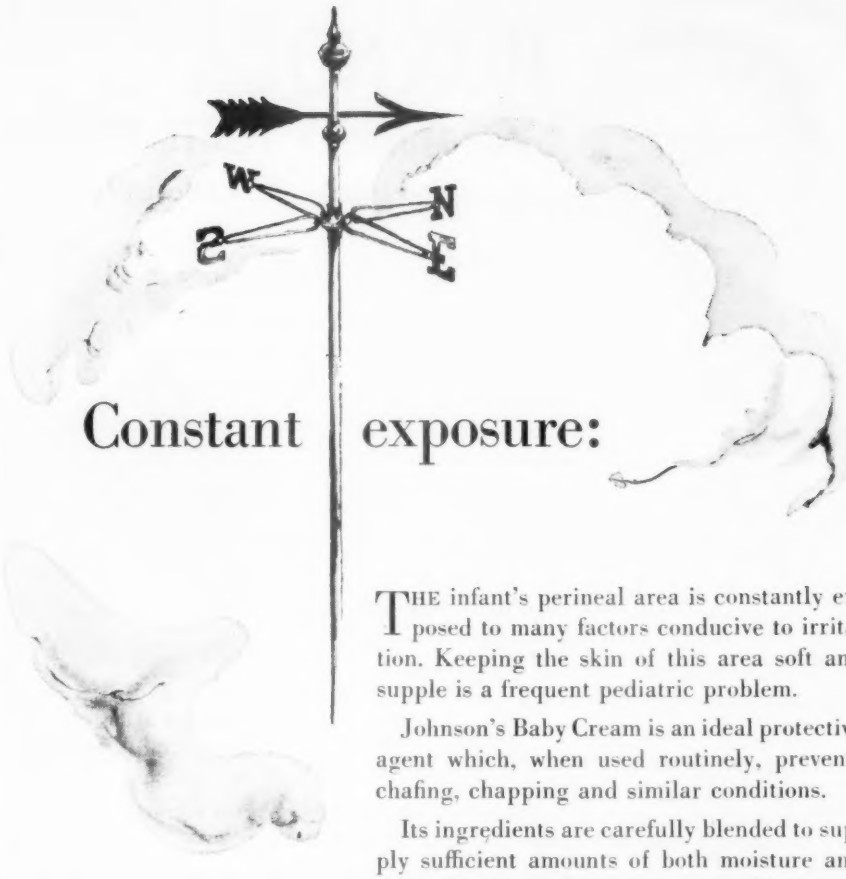

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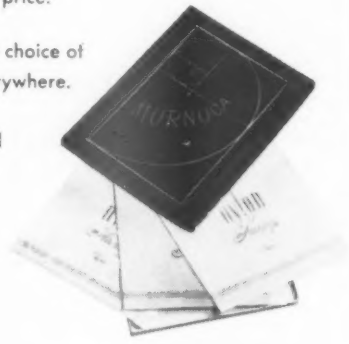

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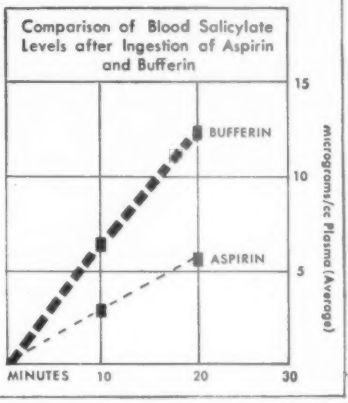

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